REPORT

of the

Task Force to Review

THE MENTAL HEALTH ACT

Presented To:
The Honourable Dr. Neil Webber
Minister of Social Services and Community Health
Government of Alberta

December 2, 1983

Alberta

SOCIAL SERVICES
AND COMMUNITY HEALTH

Ministerial Task Force to Review
The Mental Health Act

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December 2, 1983

The Honourable Dr. Neil Webber
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Community Health
424 Legislature Building
Edmonton, Alberta
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Dear Dr. Webber:

Pursuant to the provisions of Ministerial Order No. 1/82 dated January 4, 1982, we have now completed and enclose our report on the review of The Mental Health Act.

In fulfilling our mandate as described in the Ministerial Order, we were very pleased with the quality and quantity of the written and oral submissions received from interested groups, organizations and individuals in Alberta. The role which these groups and individuals played in the review process cannot be underestimated and we are very grateful for their dedicated assistance.

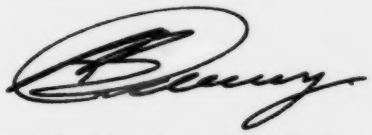
It was apparent to us from the content of the submissions received that mental health is moving into an era involving greater awareness of patient rights and greater insistence upon higher standards of treatment and care. The movement which commenced in this province in the late 1960s and early 1970s towards more community care continues. This has resulted in a more restrictive approach to compulsory hospitalization in the large facilities, and this has been reflected in our recommendations.

We have been mindful that some of the changes which we propose may appear initially to involve large expenditures of money at a time of extreme government restraint. On closer analysis, the cost may not be so great. Many of the facilities which are needed already exist and their creation would arise from redesignation of existing facilities. Some of the procedures designed to protect patient rights will have the side effect of producing savings resulting from a more restrictive

approach to hospital administration and treatment. Other proposals involve no, or no significant, expenditure of monies at all. Indeed, some of our recommendations might even be carried out by simple policy and procedural changes which do not require amendment to the legislation.

Any member of the Task Force would be most willing and pleased to meet with you and Mr. Russell or anyone else to discuss our report in detail at any convenient time.

Yours truly,



R.B. Drewry, Chairman

RBD/dac

Enclosure

cc: The Honourable Dave Russell
Minister of Hospitals and
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420 Legislature Building
Edmonton, Alberta
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OUTLINE

OF

RECOMMENDATIONS

OUTLINE OF RECOMMENDATIONS

In this Outline we highlight the recommendations made in our Report. In some cases the words used in the Outline are different from those used in the text of the Report. Where this happens, the Outline must yield to the Report. To assist the reader to find the full recommendations, the Outline gives cross-references to the appropriate heading numbers in the Report.

RECOMMENDATIONS

CHAPTER II – BASIC PREMISES

2.2 Emphasis on Community-Based Services

(1) The Minister should have a legislative obligation to establish and maintain a satisfactory system of community-based mental health services as outlined in the McKinsey and Clarke Institute Reports.

2.4 Provision of Comprehensive Treatment

(2) Wherever possible, alternatives less restrictive than compulsory hospitalization should be pursued. Intervention by the state should be a final option.

Chapter V – Criteria Justifying Compulsory Hospitalization

5.3.1 Suffering From Mental Disorder

(3) Change the definition of "mental disorder" from "lack of reason or lack of control of behaviour" (section 1(h)) to:

> "a substantial disorder of thought, mood, perception, orientation or memory, any of which grossly impairs judgment, behavior capacity to recognise reality or ability to meet the ordinary demands of life but shall include neither mental retardation nor a disorder which is restricted to the relationship between the individual and society".

5.3.2 In a Condition Presenting a Danger to Himself or Others

(4) The determination that a person poses a danger to himself or others is an appropriate criterion for involuntary commitment and should be retained. In addition, the meaning of dangerousness should not be qualified with words such as "imminent" or "serious".

5.3.3 Unsuitable for Admission to a Facility Other Than as a Formal Patient

(5) Substitute the 3rd criterion from "unsuitable for admission to a facility other than as a formal patient" in section 18(1)(c) to:

> "incompetent to give a valid consent to treatment or, if competent, refuses to be hospitalized as a voluntary patient".

5.4.1 Competence to Consent to Medical Treatment

(6) Incompetence should not be included among the criteria for involuntary commitment.

5.4.2 Need for Treatment

(7) The fact that a person is "in need of treatment" should not be included as a criterion for commitment.

5.4.3 Treatability

(8) The treatability of a person should not be included as a criterion for commitment.

CHAPTER VI – DESIGNATION OF FACILITIES

6.2 Proposal for Three Levels of Facility

(9) A three level gradation of designated facilities should be implemented:

1. short-term observation and assessment facilities within the local community.
2. medium length hospitalization facilities within the regional mental health area.
3. extended stay facilities at provincial psychiatric hospitals.

6.3 Responsibility for Establishing Facilities

(10) The Minister of Hospitals and Medical Care should have the duty of ensuring the establishment and continuance of facilities designated for observation and assessment in smaller centres throughout the province, of at least one regional psychiatric facility in each regional mental health area and of at least two provincial psychiatric facilities to serve the Province as a whole.

(11) The Minister should use all the means at his disposal to actively encourage hospital boards to undertake the functions of designation, including among other things the provision of financial incentives and assistance to make physical renovations, and to recruit, upgrade and train staff.

6.4 Specification of Standards for Facilities

(12) The government should investigate and develop an appropriate set of standards for the operation of each level of designated facility. The standards should be specified by regulation.

(13) The minimum standards should include a guarantee of a certain standard of care. The standards should cover such matters as: the use of physical restraints and isolation, the loss of privileges, hygiene, nutrition; the right of the patient to wear his own clothes and to keep and use his own possessions including toilet articles, the provision of adequate physical space for each patient, access to individual storage for a patient's private use, provision for the safekeeping of personal possessions, and other matters relating to the patient's basic living accommodation and the enhancement of his personal dignity and self-esteem.

(14) The Minister of Hospitals and Medical Care should be responsible to establish a system of monitoring the practice to ensure that the standards are met.

CHAPTER VII – ADMISSION TO A FACILITY

7.1.1 Overview

(15) A three level progression of involuntary hospitalization should be introduced. The progression would occur by way of admission firstly into a short-term designated facility (DF1) and would continue, if necessary, through to a medium term facility (DF2) and lastly to a long term facility (DF3). The original detention would be for assessment by way of observation and examination. Afterwards, the detention would be for treatment in the medium or long term facility.

7.1.2 Basis for Opinion of Physician

(16) The opinion of the physician in the admission certificates should be based on reasonable and probable grounds and that those grounds should be set out in the certificate.

7.1.3 Duty to Issue Certificate Where Criteria Satisfied

(17) A legislative duty should be placed on a physician on the staff of a DF1, DF2 or DF3 to issue a certificate in respect of a person where the physician forms the opinion that the criteria for certification are satisfied.

7.2 Admission to a DF1

7.2.1 Issue of Admission Certificate (section 14, 19(2))

(18) Section 14 of the Mental Health Act should be modified to provide for the issuance of a certificate of admission as opposed to a conveyance and examination certificate to a DF1 for the purpose of observation and assessment.

(19) A third criterion should be added for the criteria to admit a patient involuntarily to a DF1, namely that the person be "incompetent to give a valid consent to treatment, or, if competent, refuses to be hospitalized as a voluntary patient."

(20) The certificate of admission should be issued no later than 24 hours after the examination.

7.2.2 Effect of Admission Certificate

(21) Section 15(1) of the Mental Health Act should be amended as follows:

1. the certificate should name the facility or identify the level of facility to which conveyance is authorized.
2. the authority in paragraph (a) to detain the person during conveyance should be qualified so as to authorize the exertion of minimal restraint.
3. the authority to treat at the DF1 level should be restricted to the minimum treatment that in the opinion of the physician is essential to care for, detain and control the person for the purpose of observation and assessment.

(22) Section 15(2) of the Mental Health Act should be amended as follows:

1. the provision of treatment in paragraph (b) should be restricted to the "minimum" treatment that in the opinion of the physician is essential to care for, detain and control and person named in the certificate for the purpose of observation and assessment.
2. where restraint is necessary under paragraph (c) the restraint employed should be the minimum necessary to care for, detain and control the person.
3. the period authorized for observation and examination should be increased from 24 hours to not more than 96 hours.

7.2.3 Obligation to Examine (section 17(1))

(23) Section 17 should be amended to include reference to examination by a physician on the staff of the facility.

(24) Section 17 should be amended to make the obligation to conduct the examination at any time within 96 hours of the time the person arrives at the facility, as appropriate in the circumstances, as opposed to "as soon as possible".

7.2.4 Disposition After Examination (section 17(2)

(25) Section 17(2) should be amended to require release unless within the 96 hour period (as opposed to the existing 24 hour period) a member of the staff of the DF1 issues a certificate of admission to a DF2 or to a DF3.

7.3 Admission to a DF2 or DF3

7.3.1 Issue of Admission Certificates (section 18(1))

(26) Section 18(1) of the Mental Health Act should be adopted with the following modifications:

1. the opinion to issue certificates of admission should be based on reasonable and probable grounds.
2. the third criterion should be reworded to say

   "incompetent to give a valid consent to treatment or, if competent, refuses to be hospitalized as a voluntary patient".
3. the certificate should be issued not later than 24 hours after the examination.

7.3.2 One Certificate to be Issued by Psychiatrist on Staff of Facility (section 18(2))

(27) One of the admission certificates should be issued by a member of the staff of the facility to which the person examined is intended to be admitted. It should be added that this examination could be done by a psychiatrist at the DF2 and DF3 levels of facility. Further, the other certificates should be issued by the physician on the staff of the same or another facility within the province. The physician on staff should be expected to have developed some specialized knowledge of mental disorder, although not as much as a psychiatrist.

7.3.3 Effect of Two Admission Certificates (section 19(1))

(28) The admission certificates should be required to be issued within seven days of each other. The initial period of detention at a regional psychiatric facility (DF2) should be 14 days, not one month as it is now.

7.3.4 Effect of One Admission Certificate (section 19(2))

(29) One Admission certificate to a DF2 or DF3 should have the effect of a certificate of admission to a DF1. Conveyance and examination certificates should be abolished.

7.4.1 Extension of Period of Detention (section 20(1))

(30) Section 20(1) should be amended as follows:

1. the opinion of each of the physicians should be based on reasonable and probable grounds.
2. the third criterion should be reworded to say:

   "incompetent to give a valid consent to treatment or, if competent, refuses to be hospitalized as a voluntary patient".
3. the certificate should be issued within 24 hours of the examination.

(31) Section 20(2) should continue to require at least one of the certificates to be issued by the staff of the facility where the examination was made. However, that staff member should be a psychiatrist. The other certificate may be issued by a physician.

7.4.3 Effect of Two Renewal Certificates (section 20(3))

(32) The authority conferred by section 20(3) should remain. The time periods for renewal should be altered as follows:

1. only one renewal at a DF2 for not more than 14 days. Accordingly, no person should be detained as an involuntary patient at a DF2 for more than 28 consecutive days.
2. the next renewal should not be for more than 60 additional days (at a DF3).
3. any subsequent renewal should not be for more than 180 additional days.

(33) Section 20(4) and section 20(5) should remain unchanged. Accordingly, an involuntary patient whose certificates have expired is a voluntary patient and must be informed of that fact. An involuntary patient may agree to become a voluntary patient and his hospitalization may be continued in accordance with the by-laws of the Hospital Board and the certificate shall be deemed to be cancelled.

7.7 Saving Where No Psychiatrist on Staff

(34) If by reason of emergency the facility is temporarily without a psychiatrist on its staff, the requirement that one of the certificates be issued by a psychiatrist may be waived.

CHAPTER VIII – CONTENTS OF CERTIFICATES

8.1 Contents (sections 16, 18(3), 21)

(35) In addition to what the certificate must now show according to section 16, 18(3) and 21 of the Mental Health Act the certificate should also show the following:

1. the address of the physician issuing the certificate.
2. whether the physician issuing it is a member of the staff of a facility and, if so, the name of the facility.
3. the reasonable and probable grounds on which a physician formed his opinion that the person was suffering the criteria outlined in 21(c) and the additional criterion that the person is incompetent to give a valid consent to treatment or, if competent, refused to be hospitalized as a voluntary patient.

The facts substantiating the opinion should be clearly stated in narrative, not summary or abbreviated form, and the physician should use behavioral descriptions rather than diagnostic categories.

4. the facility to which the person identified is intended to be admitted.
5. the time of issue followed by the signature of the issuing physician as well as the date.

8.2 Validity

(36) The saving section under section 44 is far too wide. To be valid, a certificate must be complete. To test the sufficiency of the grounds given as the basis for the opinion of the issuing physician should be that the certificate discloses on its face the reasonable and probable grounds which to an objective observer would warrant detention under the Act. If this test is not met or the certificate is otherwise incomplete, it should be invalid.

CHAPTER IX – APPREHENSION FOR EXAMINATION

9.2 Proposal for the Issue of a Directive by an Approved Mental Health Professional

(37) An approved mental health professional should be authorized to issue a directive requiring a person to be examined by a physician.

9.2.3 Meaning of "Approved Mental Health Professional"

(38) Subject to the approval of the Minister, the professional associations for each profession should establish a criteria for registration of "approved mental health professionals", create registration procedures and provide procedures for ongoing assessment of registrants.

9.2.4 Basis for Issue of Directive

(39) A directive may be issued by an approved mental health professional, where he is of the opinion based on reasonable and probable grounds, that a person is:

1. suffering from mental disorder.
2. in a condition presenting a danger to himself or others.

3. unwilling to be examined by a physician.

9.2.5 Contents

(40) The directive should be written in simple language. It should require the patient to present himself, in the company of the mental health professional, for examination by a physician of the person's choice or by a physician on the staff of a DF1 within 24 hours of personal service.

(41) The directive should state:

1. the name, address and profession of the person issuing it.
2. the facts which caused the mental health professional to believe that the person satisfied the criteria outlined above, distinguishing the facts observed by him from the facts communicated to him by others.
3. the date and time when the belief was formed.
4. the date and time of issue.
5. the date and time of service.

(42) In addition the directive should include a statement to the effect that the registered mental health professional who issues it is willing to set up an appointment with the physician of the patient's choice, provide him with transportation, accompany him to the physician and give such other assistance as he can to help the patient satisfy the requirements of the directive.

(43) The directive should state that in the event of failure by the person named to comply, the mental health professional may bring an information under oath before a provincial judge for the issue of a judicial warrant for apprehension.

9.2.6 Service

(44) The directive should be served personally by the mental health professional issuing it.

9.2.7 Effect

(45) The directive should constitute authority for a physician to examine the person named in the directive when, within 24 hours of its service, the person attends for examination in the company of the mental health professional who issues the directive.

9.2.8 Failure of Person to Comply

(46) The failure of the person named in the directive to comply would lead to proceedings being taken by the mental health professional to obtain a judicial warrant for apprehension. The directive itself would have no legal authority.

9.3 Judicial Warrant for Apprehension (section 22)

(47) We recommend that section 22(1) be continued. If a mental health professional brings the information however, the information should spell out the steps taken by the mental health professional to secure compliance with the directive and the circumstances of the failure to comply. A copy of the directive should be attached to the information.

9.3.2 Basis for Decision of Judge (section 22(2))

(48) The person who lays the information under section 22(2) should be required to appear before the Judge for questioning on the information.

(49) The proceedings should be on the record; a Clerk should be present to transcribe it or it should be recorded in accordance with the Mechanical Recording of Evidence Act RSA 1980 Chapter M-11.

(50) The warrant should be based on current information. However, where possible, the person's past medical history should be made known to the Judge. The Judge should also be informed of previous warrants, if any, and the outcome of such warrants.

9.3.3 Powers of Judge (section 22(2)

(51) The Judge should continue to be authorized to issue a warrant to apprehend the person for examination. He or she should also be empowered to order a physician to visit and examine the person who is the subject of the warrant.

9.3.4 Effect of Warrant (section 22(3) and (4))

(52) The Peace Officer acting on the warrant should be informed on the background of the person named in the warrant and of the events leading to its issue. Preferably, the police officer making the apprehension should be wearing plain clothes and driving an unmarked vehicle. The warrant should have the effect of a certificate of admission to a DF1.

9.3.5 Duration of Warrant

(53) The warrant should remain outstanding for only seven days. There should be a procedure for a return of the warrant to the Provincial Judge who issued it together with a statement as to its disposition. The statement of disposition should also go to the person who brought the information.

9.4 Peace Officer's Power (section 23)

(54) Section 23(1) of the Mental Health Act should be amended as follows:

1. the opening words of section 23(1) should be rewritten to allow a peace officer to intervene on the basis of reasonable and probable grounds for belief rather than on his personal observations.
2. the word "apparently" at the beginning of paragraph (a) should be deleted.
3. paragraph (c), is an irrelevant consideration and should be deleted.

(55) The peace officer should convey the person to a DF1 rather than any facility for examination.

(56) A person conveyed to a facility under the peace officer's power should be deemed to be a person in respect to whom a certificate of admission to a DF1 has been issued.

CHAPTER X – MATTERS RELATING TO CONVEYANCE AND ADMISSION

10.1 Reception of Person by Facility

(57) The reception for observation and assessment at DF1 should be mandatory where the person is presented pursuant to the authority of a certificate issued by any physician, judicial warrant or peace officer's apprehension.

(58) A DF1 Physician may authorize conveyance for observation and assessment at a DF2 within the region, if necessary. It should then be mandatory for a DF2 to receive for observation and assessment but not necessarily to admit, a person certified or admission by a DF1 physician.

(59) The responsibility of the peace officer or other person escorting a person to a facility should end when he turns the person over to the staff of the facility to undergo the check-in procedure.

10.2 Refusal to Hospitalize

(60) The facility physician who forms the opinion that a compulsory hospitalization is not justified should be required to state his reasons for refusing admission in a written certificate. The certificate should be given to the person who is subject to the examination, any person he names to represent him, the nearest relative and the referring source, if any.

10.3 Conveyance To and From the Facility

10.3.1 Responsibility to Convey

(61) The responsibility for conveyance should not be assigned in legislation.

10.3.2 Arrangements for Conveyance

(62) Once a person has been conveyed to a DF1 or other facility, the Board at the detaining facility should be responsible for transportation arrangements thereafter.

10.3.3 Cost

(63) The cost of conveyance of an involuntary patient and his transportation home should be born at public expense whether or not the detention results in hospitalization.

10.3.4 Transfer of Medical Records

(64) On any conveyance to or transfer between facilities, copies of the information essential to maintain the continuity of medical care must accompany the patient.

CHAPTER XI – RIGHTS OF PATIENT

11.2 Right to Be Informed of the Reasons for Detention and of the Right to Review (section 24(1))

(65) Both an oral explanation and a written statement of the reasons for the hospitalization should be given. The oral explanation should be given at the time when the patient is capable of comprehending. The written statement should include copies of the certificates of admission or renewal authorizing the detention. Further, the patient should also be given both an oral explanation and a written statement of the right to review. The obligation to inform should be placed on the Board of the facility.

e(66) The patient's nearest relative should receive the same oral explanation and written statement as the patient. A person named by the patient as his representative should also receive an oral explanation and written statement. Notification to the nearest relative, as defined in the act, should be mandatory in all cases.

11.3 Right to Name a Representative

(67) The patient should have the right to name as his representative any person he foresees as being concerned for his well-being and likely to represent his interests.

11.4 Right to the Assistance of an Interpreter (section 24(2))

(68) The patient should have a right to an interpreter at proceedings conducted before the Review Panel.

11.5 Right to an Independent Medical Opinion

(69) An involuntary patient should be entitled to one independent medical opinion from a physician of his choice funded by Alberta Health Care. The right should recur with respect to every pair of certificates issued. An involuntary patient should be further entitled to any number of medical opinions upon examination by physicians of his choice at his own expense.

11.6 Right to Security (section 13(2))

(70) The Board of a facility should continue to be required to provide a level of security reasonably required for each patient for the purpose of protecting both the patient and others. The level of security should be determined on an ongoing basis rather than every six months, and be provided as is needed at any given time.

11.7 Right to be Free from Abuse

(71) The right to be free from abuse should be legislated. The following definition of "abuse" should be considered:

"any activity which physically, mentally or emotionally causes injury, damage, undue discomfort, elicits fear or takes an unfair advantage of a client and is not part of his specific written treatment plan or approach. This includes verbal and physical assault".

(72) Patient abuse should constitute just cause for dismissal of the employees committing the abuse.

11.8 Right to Unobstructed Communication (section 30)

(73) Section 30's right to unrestricted written communication should be expanded to include the right of the patient to have access to a telephone and the right to make and receive unmonitored telephone calls or to have such calls made for him, at his own expense at all reasonable times.

11.9 Right to Receive Visitors (section 31)

(74) Section 31 should be reworded to permit a patient to receive visitors each day at all reasonable times and in all reasonable circumstances unless the physician considers that visiting with a given individual would be detrimental to the patients health. The section should continue to except a solicitor acting for the patient from section 31(1). The exception should also include a person named by the patient as his representative and members of the patient advocacy service.

11.10 Rights of Voluntary Patients

(75) A voluntary patient in a facility should have the right to be informed of his status at any and all times. He should be entitled to the protection of the confidentiality of and access to his medical records. He should be entitled to notification of the rights associated with his status. Finally, he should be entitled to the assistance of the patient advocacy service in seeking clarification.

11.11 Channels of Complaint – Ombudsman

(76) All involuntary patients throughout the province whether under observation and assessment at a DF1, or under certificate of admission at a DF2 or DF3 should be entitled to call upon or resort to the services of the ombudsman.

CHAPTER XII – NOTIFICATION OF RIGHTS

(77) In addition to the notification of rights noted above, we would obligate the boards of facilities at all three levels to take reasonable steps to ensure that both involuntary and voluntary patients are informed of their rights at all times. A statement of the rights of both involuntary and voluntary patients should be posted in prominent locations in all wards throughout the hospital. It is suggested that a standardized booklet of rights consistent with the Act should be prepared for distribution to involuntary and voluntary patients upon admission. The booklet should also be available in every psychiatric nursing unit.

CHAPTER XIII – REVIEW BY REVIEW PANEL

13.2.1 Establishment of Review Panel

(78) The Minister should continue to bear responsibility for the establishment of review panels.

13.2.2 Composition (section 7(2))

(79) Each review panel should continue to be composed of a psychiatrist, a physician, a solicitor (who shall be chairman) and a person representing the general public.

(80) The Minister should not appoint individual review panels. He should instead appoint a roster of panelists to each category of membership on a panel.

(81) Section 7(3), which enables the Minister to designate a Vice Chairman of a review panel and to appoint one or more alternate members, should be repealed as the roster system of appointment will render this position unnecessary.

(82) Section 8(4) which provides for periodic review of the appointment of members should be amended and a five year maximum should be placed on appointments to the panel roster.

13.2.5 Prohibitions on Membership (section 9)

(83) The safeguards now contained in Section 9 that prohibit a person who is actively serving as a member of the staff of a facility from sitting on the review panel, are adequate.

13.2.6 Additional Protection Against Bias

(84) No two successive applications by any one patient should be heard by the same review panel.

13.2.7 Replacement of Members Who Cannot Act (section 7(3))

(85) Section 7(3) allows a panel member to be substituted during the course of the hearing. This section should be deleted.

13.2.8,.9,.10 Section 8(1), (2), (3)

(86) Quorum should continue to be four members of the panel. Each member shall continue to have one vote. The decision of the majority of the members of the panel should continue to be the decision of the review panel.

13.2.11 Duties and Powers of Review Panel (section 10(1))

(87) Review panel members should continue to have all the powers of commissioners appointed under the Public Enquiries Act.

13.2.12 Provision of Assistance to Review Panels (section 10(2))

(88) The Minister should continue to be responsible to provide secretarial, legal, consultative and other assistance to review panels as may be required. In addition, this section should include the responsibility to provide the assistance of an interpreter as required by section 14 of the Charter.

13.2.13 Appointment of a Co-ordinator of Review Panel

(89) A co-ordinator should be named to constitute the panels and to attend to other administrative details of the review panel. 13.3

Initiation of Review

13.3.1 Application to Review Panel (section 25(1) and (2))

(90) An involuntary patient or a person on his behalf should be able to apply to a review panel for cancellation of certificates of admission or renewal by sending notice of the application to the co-ordinator of review panels in the prescribed form. Section 25(1) should be amended in order to reflect this change.

13.3.2 Frequency of Review

(91) Section 25(2) should continue to entitle the patient to make one application for review in respect of each pair of admission or renewal certificates issued. Section 25(3) should continue to entitle the Minister, the Director or a Board to apply for review at any time.

(92) Review should be automatic in the case of every patient, involuntary or voluntary, who has been hospitalized for a continuous 180 day period. The 180 day period of hospitalization shall not be considered to have been interrupted or terminated by the reason only that the patient has been on leave of absence from the hospital for a part of that time.

13.3.3 Speed of Review (section 28(1))

(93) The period between the receipt of the application and the hearing should be shortened. The applicant should be notified of the date, time and place and purpose of the hearing within seven days from the date the application is received by the co-ordinator of review panels. The hearing should be scheduled no later than 14 days after the application is received. The applicant should have seven clear days notice before the hearing to notify his witnesses, if any, and otherwise to prepare his case. The power of the Minister to extend the time for hearing beyond the 28 day period is inappropriately placed and should be deleted.

13.4.1 Notice of Hearing (section 26(1))

(94) The co-ordinator of review panels should send out the initial notices. The patient and any person acting on his behalf should have at least seven clear days in which to prepare his case. Notice should be given to the Board of the facility in which the patient is detained in order to allow arrangements to be made for the attendance of the responsible physician at the hearing. Notice should go to the medical director of the facility to enable him to instruct his staff concerning the effects of treatment on the patients presentation before the review panel. The nearest relative and the person named by the patient as his representative, if any should receive notice. Any other person whom the chairman believes may be affected by the application should also be notified.

13.4.2 Investigation by Review Panel (section 26(2))

(95) The review panel should continue to have full powers of investigation for the purpose of gathering in all relevant evidence in deciding cases correctly. The discretion to invite the patient to the hearing or not should be deleted. The patient should have the right to attend and participate as a party to the hearing.

13.4.3 Documentation Before Review Panel

(96) Several documents should be before the review panel:

1. the detaining certificates.
2. the application for review.
3. a summary of the patient's medical records.
4. a report prepared by the physician responsible for the treatment of the patient in the facility summarizing;
   (a) the current mental condition of the patient,
   (b) his present treatment and treatment plan with particular reference to any treatment which is likely to affect the patient's appearance, demeanour and level of functioning at the hearing, and
   (c) the reasons why the physician thinks that the patient still satisfies the criteria for compulsory hospitalization.
5. a home circumstances report prepared by a social worker or other member of the hospital staff; and
6. a statement of any investigation conducted by the review panel prior to the hearing of its findings.

13.4.4 Access by Patient to Documentation Before Review Panel

(97) The patient should have access to all documentation and other evidence before the review panel. He should have the right to see and comment on anything written, and to hear and comment on anything said at the hearing. An exception to the principal should be where disclosure of information might seriously endanger the safety of a third person. Such a decision should be made by the review panel on the application of the responsible physician or any other person in charge of the records who objects to the release.

13.4.5 Condition of Patient at Time of Hearing

(98) Medications or other treatments should not be used for the purpose of adversely interfering with the patients ability to recognize his status and contest the detention nor should they unduly inhibit the patients ability to comprehend and participate in the hearing before the review panel.

13.5 Conduct of Hearing

13.5.1 Representation of Patient (section 26(1), 27(2))

(99) The applicant should be able to be represented by a person who is not necessarily a lawyer, but who will speak on behalf of the applicant.

13.5.2 Conduct of Review in Private (section 27(1))

(100) The hearing should be held in private except where the patient requests that it be held in public. The review panel should not have the discretion to exclude members of the public when the patient wants them to be present.
In cases where the hearing is conducted in private, the chairman should continue to have the right to give permission to persons to be present during the hearing.

13.5.3 Power to Exclude Patient from Hearing (section 27(2))

(101) The power to exclude the patient from the hearing by the review panel should be repealed. This power would infringe the patient's fundamental right to hear the evidence put forward in support of the detention.

13.5.4 Formality of Hearing

(102) The atmosphere of the hearing should be dignified and solemn. The development of the hearing and the presentation of evidence should occur in orderly fashion. The possibility of bias in either appearance or fact should be studiously avoided. There need not be strict adherence to the rules of evidence however.

13.5.5 Swearing of Evidence

(103) Evidence should be sworn at the hearing. The patient however, should not be precluded from testifying on the basis that there is doubt as to his competence to swear an oath. The patient should be permitted to testify unsworn in this circumstance.

13.5.6

(104) The patient should enjoy all the benefits of natural justice to which he would be entitled as a party to a civil suit. Accordingly, the patient should have an opportunity to affirmatively present his case against detention as well as to contradict the case for detention.

The chairman of the review panel should use his power, as a commissioner under the Public Enquiries Act, of summoning witnesses who can give relevant evidence where the patient requests that he do so.

(105) The testimony of the physician responsible for the care and treatment of the patient at the facility is necessary evidence and the chairman should be required to secure his attendance, using the power to compel if necessary. The physician should not be a party to the proceedings in an adversarial sense, although his opinion may be opposed to that of the patient seeking review.

13.5.7 Order of Evidence

(106) The evidence should be presented in an orderly manner. The following is a proposed order:

1. verification of the patients present condition by review of the patient's medical record and questioning of the responsible physician about medication and other treatments.
2. receipt of a statement from the responsible physician.
3. presentation of the patient's case including his response to the statement of the physician.
4. testimony by the patient's witnesses, if any.
5. testimony by relatives or other interested persons.
6. response by the responsible physician.
7. reply by the patient.
8. summation and argument.
9. departure of the participants.
10. deliberation and decision by the review panel.

The order of presentation of evidence should not be inflexible and should not be solidified in legislation.

13.5.8 Power of Review Panel to Order an Independent Medical Examination

(107) The review panel should be able to request that the patient submit to an examination by an independent physician or psychiatrist whom it names. The review panel should assume the costs of any examination which is requests.

13.5.9 Burden of Proof

(108) The burden of proving that the patient meets the criteria for a hospitalization should lie on the facility detaining him. If the case for confinement is not made out, the patient should be released. There should be no requirement on the patient to first make out a prima facia case against his detention.

13.5.10 Power to Adjourn (section 27(5))

(109) The chairman should continue to have the power to adjourn the hearing for any reasonable time up to 21 days. The chairman should be able to adjourn on as many occasions as fairness dictates where the patient applies for the adjournment. However, he should not adjourn more than once on the request of anyone else. The involvement of the Minister in permitting extended adjournments is inappropriate and this power should be removed.

13.6 Disposition

13.6.1 Cancellation of Certificates (section 28(2)(a))

(110) Where the review panel is of the opinion that the patient no longer poses a danger to himself or others, or that the mental disorder has been cured, it should be obliged to cancel the certificate.

The review panel should have the power to delay, for up to two weeks the discharge of a patient whose certificates have been cancelled to allow time for hospital staff to make suitable after care arrangements.

13.6.2

Refusal to Cancel Certificates (section 28(2)(b))

(111) Where the review panel is of the opinion that the criteria for hospitalization are present, it should be obliged to refuse cancellation of the certificates. No conditions should be attached to the refusal. Section 28(2)(b) should be amended accordingly.

(112) In a proper case, the patient should be allowed to test his ability to cope in the community. The chairman of the review panel should use his power of adjournment to enable the medical director to exercise his discretion to grant a leave of absence under section 38. Adjournment would be appropriate where the review panel is not convinced that the patient's certificates should be cancelled, although he appears to be making good progress in this direction.

13.6.3 Reasons for Decision

(113) Review panels should be required to give written reasons for decision.

13.6.4 Notice of Decision (section 28(3), 28(5))

(114) Section 28(3) which requires the chairman of the review panel to send a copy of the decision to the patient within seven days of the decision should be rewritten to require the decision to be given to the applicant within seven days of the hearing.

13.6.5 Notification of Right to Appeal (section 28(4))

(115) Section 28(4) requires the written report of the decision of the review panel to include a statement of the right of the applicant to appeal the decision to the Court of Queen's Bench where the review panel refuses to cancel the detaining certificates. The statement should also advise the patient that he has 14 days from the receipt of the decision to launch the appeal. The notification of the right to appeal should be given in writing and served together with the review panel's decisions and reasons.

13.6.6 Duty of Board to Comply with Decision (section 28(6))

(116) The duty outlined in section 28(6) that directs the Board of the facility in which the involuntary patient is detained to take whatever action that may be required to give effect to the decision of the review panel should be retained.

13.7 Record of the Proceedings

(117) The chairman of the review panel should be responsible to ensure that a record is maintained, and to forward it upon completion of the review of the proceedings, to the co-ordinator of review panels for preservation. The record should be available, on request, to the patient, the person named by the patient as his representative and his legal council, if any.

13.8 Publication of Proceedings (section 27(4))

(118) Where the patient requests that the hearing be held in public, there should not be a stringent restriction on publication. However, as a general rule, personal identity should be protected from disclosure in any publication of the proceedings. If the patient requests that names be published, the review panel should be able to permit it where disclosure would not be injurious to the personal interests, reputation or privacy of the persons involved. In cases where the proceedings are held in private, section 27(4) should continue to apply to the proceedings themselves.

13.9 Additional Powers of Review Panel

13.9.1 Scrutiny of Withdrawn Applications

(119) The review panel should have the power to inquire into the reason for the withdrawal of an application and to proceed with the hearing if the applicant wishes.

13.9.2 Hearing of Applications to Withhold Portions of Patients Record

(120) The patient should have a general right of access to his medical record, subject only to an order by the review panel permitting parts of the record to be withheld where disclosure would jeopardize the security of third persons.

13.9.3 Review of Treatment Where Patient Objects

(121) An involuntary patient who objects to the treatment being given to him may make application to the review panel for a review of that treatment and an order that the treatment be discontinued.

13.9.4 Review of Decision to Transfer Patient

(122) Section 29 permits a person convicted of a criminal offence who is sent to a facility for treatment to apply to the review panel for an order transferring him back to a correctional institution. This should be continued.

(123) A patient who objects to a decision to transfer him to another facility of the same level should also be able to apply for a review of the decision by the review panel.

13.10 Orientation of Review Panel Members

(124) An orientation program for review panel members should be instituted.

13.11 Annual Report to Minister

(125) The co-ordinator of review panels should compile an annual report of the activities of the review paneis during the preceding year for presentation to the Minister. The Minister should be required to table the annual report in the legislature.

13.12 Appeal from Decision of Review Panel (section 32)

(126) Section 32(1) should continue to permit the right to appeal to be limited to the applicant. The 14 day appeal period should commence from the date of receipt of the decision by the patient.

(127) The Court should either uphold the decision of the review panel or quash it. The power to make any other order the Court considers just should not be among the options. The Court should make a decision about the cancellation of the certificates first. Further, the Court should not have the power to remit the decision to the review panel for reconsideration.

CHAPTER XIV – REVIEW BY COURT

14.1 Statutory Right of Review

(128) There should be a statutory right of review by the Court of Queen's Bench in addition to the right of review by a review panel. The Court should have the power to prevent detention before it occurs (e.g. after the issue of a certificate of admission to a DF1 but before apprehension for conveyance pursuant to it); to delay it until a hearing has been held; to cancel certificates which have been issued; or to refuse to cancel certificates.

14.2 Habeas Corpus

(129) The right to apply for an order in the nature of *habeas corpus* should be specifically preserved in the Act.

CHAPTER XV – TREATMENT

15.2 The Right to Treatment

(130) The right to up to date and competent treatment is a legitimate *quid pro quo* for the deprivation of liberty and commitment against the patient's wishes. Any facil-

ity detaining patients under the Act should have to meet modern standards which would include fully qualified psychiatrists in sufficient quantity to handle patient loads, adequate back up staff, and proper medical equipment. The standards should be described in regulations to the Act which should specifically set forth the more important requirements and include a requirement that the hospital obtain and maintain accreditation with an appropriate hospital accrediting body.

15.3 Control of Treatment Types

(131) The setting of standards to determine the medical soundness of treatment types is a medical question and should be left up to the medical profession.

15.4 The Question of Consent to Treatment

(132) Involuntary patients should have a right to object to treatment. Upon objection by a patient, competent or incompetent;

(a) the patient should, within a reasonable period of time, have a right to obtain an independent psychiatric opinion at the expense of the state.

(b) if the attending physician wishes to proceed with the proposed treatment, he should apply to the review panel for a hearing to determine whether or not the patient's objection to treatment should be overridden.

(c) the review panel should override the objection to consent only upon being satisfied after hearing the evidence of the attending physician, a staff psychiatrist, or an independent psychiatrist, if any, that:

(i) each has examined the patient;

(ii) they are of the opinion that the mental condition of the patient would be or is likely to be substantially improved by the specific psychiatric treatment or course of psychiatric treatment proposed;

(iii) that the mental condition of the patient will not likely improve without the specific course of treatment proposed;

(iv) that the proposed treatment will render the patient less dangerous, and

(v) that any alternative treatments are less adequate.

Proxy Consent

A patient should be permitted to object to treatment through the proxy of his legal representative or nearest relative.

15.5 Unusual Treatments

15.5.1 Electroconvulsive Therapy

(133) The use of electro-convulsive therapy treatment should not be regulated differently then other treatments.

15.5.2 Psychosurgery

(134) Psychosurgery for involuntary patients should be compulsorily reviewed by the review panel. The review panel should follow the criteria for permitting treatment contrary to a patient's wishes, it should consider the wishes of the patient, it should consider not only the medical considerations, but the implications of the surgery on the overall health of the patient and it should permit its use only as a last resort.

15.5.3 Aversive Therapy

(135) Acts which are humiliating, painful or abusive on the one hand but offer only minor or insignificant benefits on the other hand, should be discarded.

15.6 Experimental Treatments

(136) No experimental medical treatment should be performed upon involuntary patients with or without their consent.

15.7 Compulsory Outpatient Treatment

(137) No compulsory outpatient treatment should be legislated.

CHAPTER XVI – PATIENT ADVOCACY

16.4 Limited Legal Advocacy

(138) A legal advocacy service providing limited legal services for involuntary patients free of charge should be established under the Act. It should minimally have the following features;

(a) it should be staffed by a lawyer on a full time basis.

(b) the service should not report to the government directly, but to an independent agency.

(c) the service should be highly visible and accessible to its patients. Accordingly, sufficient facilities should be provided within the hospital to enable the service to fulfill its functions.

(139) The legal advocacy service should provide the following services:

(a) advise patients individually of their rights upon admission.

(b) act for patients in all matters pertaining to their release.

(c) act for patients in all matters pertaining to attempts to provide treatment to patients without their consent.

(d) represent patients in all related procedural matters and in such matters as obtaining access to medical records.

(e) act for patients in matters pertaining to guardianship and appointment of committees.

(140) Non-lawyer advocates should also be established. Their services would be to provide support to patients and would include:

(a) providing non-legal guidance to patients.

(b) investigating alternatives to hospitalization.

(c) representing patients in minor administrative proceedings such as loss of privileges, and make initial investigations of minor patient complaints.

This service should not necessarily be legislated. As a matter of policy all hospital boards should be encouraged to permit the introduction of such a service.

CHAPTER XVII – PATIENT RECORDS

17.3 Scope of Records Provisions

17.3.1 Facilities and Services

(141) The records provisions in the Act should apply to records maintained in all facilities, (DF1, DF2 and DF3) designated under the Act and in any other mental health service established by the Minister.

17.3.2 Patients

(142) The confidentiality of the records of both voluntary and involuntary psychiatric patients should be protected, as they are now.

17.3.3 Meaning of "Record"

(143) "Record" should not be defined in the Act, nor should the contents of the record by defined. Records should be protected from disclosure except as permitted by the Act.

17.4 Prohibition of Disclosure

17.4.1 General Rule of Nondisclosure

(144) A general rule of nondisclosure is inherent in section 37. This rule of nondisclosure is the basis; the other rules being the exceptions to this rule.

17.5.4 Disclosure to Patient

(145) The patient should continue to have "a special right of access" to his records. Every person should generally be entitled to see all records which are kept about him. The entitlement should not be limited to review panel hearings. Entitlement should be as of right and not, as now, in the discretion of persons in charge of the record, or if that authorization can not be obtained, on Order of the Court.

The access would be subject only to an Order by the review panel permitting the withholding of a part of the record where disclosure would jeopardize the confidence or security of a third person.

17.5.5 Exception for Security or Confidence of a Third Person

(146) The person in charge of the records should have no more than 14 days from the date of the patient's request for access within which to bring the application to the review panel to withhold any part of the patient's record.

(147) The only reasons upon which the person in charge of the record may bring such an application is risk of harm to a third person. Risk of harm to the patient himself should not be a factor.

(148) In deciding whether to make an order to withhold a portion of the record from the patient, the review panel should weigh the patient's interest in and need for disclosure against the risk of harm to the security or confidence of a third person by disclosure and the possibility of jeopardizing the candor of other third persons in supplying information in the future.

(149) The onus of demonstrating why any portion of the record should not be disclosed to the patient should fall on the person seeking the order to withhold.

(150) Both the patient and the person in charge of the record should have the right to appeal the decision of the review panel to a Judge of the Court of Queen's Bench and there should be no further appeal.

17.6 Disclosure with Patient's Consent or in His Best Interests

(151) Where the patient has the requisite mental competence to give a valid consent to the release of information, the disclosure should be made as of right. The right should be subject only to the right of the person in charge of the record to apply to the review panel for an order to withhold a portion of the record.

(152) Where the patient is incompetent to consent to the disclosure of information, it should be made possible for persons in charge of the record to make disclosures, where, in the opinion of the persons in charge of the record, it would be in the best interests of the patient.

(153) Section 37(6)(c)(d)(e)(f)(i) and (l) should be retained.

(154) Where the person in charge of the record is in doubt about whether the record should be disclosed, he should be entitled to apply to the review panel for directions.

17.7 Disclosure for a Public Purpose

(155) Disclosure should be possible without the consent of the patient in certain cases when the public interest and need for disclosure outweighs the risk of injury to the patient, to the physician, patient relationship, and to the treatment services which may result from the disclosure.

(156) The disclosures for public purposes authorized by section 37 (3), (6)(f)(g)(h)(j)(k)(m), (7), and (8) should be preserved.

(157) Access to patient records without consent should not be extended to other pro-

fessional bodies for the purpose of investigating the conduct or capability or fitness of one of its registered members to practice their profession.

(158) When a senior official of the hospital or health care facility or a physician believes, on reasonable grounds, that a patient has been a victim or the perpetrator of crime, he or she may so inform the police without the patient's authorization. The decision to inform the police however must be made at the deputy minister level.

(159) Legislation should be enacted to provide that, when a senior official of a hospital or health care facility has reasonable cause to believe that a patient is in such mental or emotional condition as to be dangerous to himself or others and that disclosure of information about the condition of the patient is necessary to prevent threatened danger, he or she may disclose that information without the consent of the patient.

(160) Section 37 of the Act should stipulate that disclosure in a Court of law is an exception to the general principal of non-disclosure. This exception should be legislated for disclosure pursuant to a Court order or subpoena.

17.8 Form of Authorization of Disclosure

17.8.1 Consent of Patient

(161) A blanket consent to disclose information on the record is insufficient. In order for the consent of the patient to be informed, he should know precisely what information is being released, the possible consequences of disclosure, and that he may refuse to sign the consent or later rescind or amend it. The patient's consent should be in writing and a form should be specified for such a consent.

17.8.2 Authorization by Another Person

(162) Whenever confidential information is disclosed by a person other than the patient, we believe that the authorization for the disclosure should likewise be in writing. The statement of authorization should show the authority for the disclosure, the persons or agencies to whom the disclosure is made and the purpose for which the information is disclosed.

17.8.3 Form

(163) A form should be devised for the release of information pursuant to the consent of the patient or upon the authorization of another person. The forms should be similar in content. The form should:

1) be in writing and dated;
2) state the position of the person authorizing the disclosure (patient or otherwise), be signed by him and witnessed;
3) give a date or event upon which the consent expires;
4) name or otherwise describe the health care facility or service in possession of the records;
5) name the recipient to whom the information is to be released;
6) describe the extent and nature of the information to be disclosed;

7) describe the purpose for which the information is to be disclosed;

8) state the authority for the disclosure.

17.9 Limitations on Extent of Disclosure

(164) Disclosure should be made only of as much information as is needed to meet the purpose of the disclosure. This principal should be incorporated in the legislation.

Section 37(4) should be redrafted to apply to all information obtained from patient records, and not just that disclosed for public purpose under sub-section (3).

(165) As a general principal disclosures made for public purpose should be made in a way that protects the patients' confidentiality. The protection should include the concealment of individual names where concealment does not derogate from the purpose to be served by the disclosure.

17.10 Court Application for Order to Disclose (section 37(9)(10) and (11))

(166) The patient should have access to his records as of right and should no longer need to make an application for an order to disclose his records. Accordingly, section 37(9)(10) and (11) should be repealed.

17.11 Notations on Record

(167) It should not be necessary to give the patient notice every time a disclosure is made under the authority of one of the provisions in section 37. However, any disclosure should be noted on the patient's record. The form containing the authorization for the disclosure should be kept on the patient's file. Where the patient consents to the making of a disclosure, the form should also be kept on his file.

17.11.2 Correction of Record

(168) There is a duty on the record keeper once a mistake on a record has been brought to his attention, to correct it. Accordingly, a patient need not be given a legislative right to correct inaccurate information on the record.

17.12 Sanctions for Wrongful Disclosure (section 35(5))

(169) The knowing and wilful contravention of the confidentiality provisions of the Act is a serious matter. The penalty for the offence should be increased from a maximum of $500.00 to $500.00 as the minimum penalty and $2,000.00 as the maximum.

CHAPTER VIII – TRANSFER OF PATIENTS

18.1 Transfer to Another Facility (section 39)

(170) Section 39(1) permits a board to transfer a patient to another facility, if otherwise permitted by law and subject to arrangements being made with the other board. This section should be preserved. However, the patient should have the right to apply to the review panel for a review of the decision to transfer him to another

facility of the same designation where he objects to being moved. The decision to transfer a patient from one level of facility to another level of facility will be reviewable upon the issue of certificates to detain the patient at the new facility.

18.2 Transfer for Hospital Treatment (section 40)

(171) Section 40 should be retained.

18.3 Transfer Into Alberta (section 41)

(172) Section 41 permits a director of mental health services for the Province of Alberta to issue a certificate when he has reason to believe that a person suffering from a mental disorder may come or be brought into Alberta. This section should be redrafted to refer to a Certificate of Admission to a DF1 instead of to a Conveyance and Examination Certificate. Moreover, before the director issues a certificate, he should be of the opinion based on reasonable and probable grounds that the person meets the criteria specified in the Act for the issue of a certificate of admission to a DF1.

18.4 Transfer Out of Alberta (section 42)

(173) Section 42 should continue unchanged.

CHAPTER XIX – ABSENCE FROM HOSPITAL

19.1 Leave of Absence

(174) The medical director should continue to have authority to grant a leave of absence to an involuntary patient as is now set out in section 38(1) of the Act.

(175) Section 38(2) empowers the medical director to prescribe terms and conditions for the leave. This should be continued.

19.1.3 Revocation of Leave (section 38(3))

(176) Upon the revocation of a leave of absence, the patient should have the right to apply to the review panel for the review of the case for detention. The right should exist whether or not there has been a previous hearing in respect of the current detaining certificates. The review panel should have the same powers of disposition including the power to adjourn so that the medical director may re-enstate the leave.

19.1.4 Enforcement of Revocation (section 38(4))

(177) If the patient refuses to return to the facility, or the notice under section 38(3) cannot be served, section 38(4) permits the medical director to declare the patient to be absent without leave and order any peace officer to return him to the facility. This provision should be continued, subject to the incorporation of the recommendations with respect to absence without leave (see 19.2).

19.1.5 Exemption from Leave Provision (section 38(5))

(178) Section 38(5) should be continued.

19.1.6 Calculation of Time While Patient is on Leave

(179) Time should continue to run on the detaining certificates while the patient is on leave. If the certificates expire while the patient is on leave, he should be free to continue in the community as an ordinary autonomous citizen, unimpeded by any terms and conditions attached to the leave by the medical director while the certificates remained in force.

19.2 Absence Without Leave

19.2.1 Order for Return of Involuntary Patient (section 43(1))

(180) The Board should continue to have the authority to order the return of an involuntary patient.

19.2.2 Authority of Order (section 43(2))

(181) The authority of the order to allow every peace officer to arrest, without warrant, the person named in the order should be limited to the current period of certification. The order should state the date on which the current certificate expires.

19.2.3 Calculation of Time While Patient Absent Without Leave (section 43(3))

(182) Time should continue to run on the detaining certificates irrespective of the patient's absence from the hospital. Section 43(3) should be amended accordingly.

CHAPTER XX – DISCHARGE

20.1 Authority to Discharge (section 34(3))

(183) Section 34(3) should be retained.

20.2 Notice of Discharge (section 33(1))

(184) If the patient consents, notice of the patient's discharge should be given to the patient's nearest relative and to the patient's representative.

Notice should be given to the referring source in all cases, irrespective of the patient's consent.

Notice may be given to a physician, mental health worker or agency involved in a continuing therapeutic relationship with the patient only upon the patient's consent.

20.3 Refusal of Patient to Leave (section 33(2)(3)(4) and (5))

(185) Section 33(2)(3)(4) and (5) should be retained.

20.4 Discharge Planning

(186) Discharge planning should not be required by legislation.

CHAPTER XXI – SPECIAL CONSTITUENCIES

21.1 Dependent Adults

21.1.1 Persons Hospitalized On Consent of Guardian

(187) Persons who become patients at any facilities solely as a result of the provisions and powers contained in the Dependent Adults Act and who in other respects would not be certifiable under the provisions of the Mental Health Act, should to all intents and purposes be treated as involuntary patients under the provisions of the Mental Health Act.

21.1.2 Persons Hospitalized Under a Compulsory Care Order

(188) While hospitalization of such patients at the two Alberta Hospitals should not be encouraged, we do not view any problem resulting from such hospitalization as serious enough to warrant making a recommendation that suitable facilities be provided elsewhere.

21.2 Children and Adolescents

21.2.4 Application of Mental Health Act to Children

(189) The Mental Health Act should continue to apply to children and adolescents as well as to adults.

(190) Establishment of Facilities

Facilities should be established for the psychiatric care of severely mentally disordered children and adolescents.

(191) Rights of Hospitalized Children

A minor who is hospitalized should have the same rights and protections as an involuntary adult patient. If over the age of 16, a minor should be entitled to advocacy services as of right. 21.3

Mentally Disordered Offenders

(191) A mentally disordered offender requiring treatment must fit within the criteria set forth within the Act for committal and the hospitals should accept or reject them for treatment in accordance with the policies applicable to other patients.

CHAPTER XXII – MISCELLANEOUS ADMINISTRATIVE MATTER

22.1 Director of Mental Health Services

(192) The Director of Mental Health Services should be a psychiatrist.

22.2 Role of Mental Health Councils

(193) The size of PMHAC should be reduced to a chairman plus 14 members, the members being the six Regional Council Chairmen and eight members at large.

(194) No major initiative in mental health care should be considered without giving PMHAC a reasonable opportunity to comment.

22.3 Definition of "Psychiatrist"

(195) A "psychiatrist" should be defined as a medical practitioner recognized by The College of Physicians and Surgeons as a specialist in psychiatry".

22.4 Definition of "Nearest Relative"

(196) This definition should be expanded to include common law spouse.

22.5 Liability for Hospital Charges

(197) Hospital care should be given to involuntary patients free of charge.

(198) Voluntary patients should be charged on the same basis as patients in other hospitals.

22.6 Name of Act

(199) The name of the Act should be changed to "The Mental Disorders Treatment Act".

REPORT

I. THE TASK

1.1 Establishment of Task Force

The Task Force to Review the Mental Health Act was established by Ministerial Order No. 1/82 on 4 January 1982 by the Honourable Bob Bogle, Minister of Social Services and Community Health.

1.2 Function

The Task Force was asked to review the Mental Health Act and, in particular, to:

(a) Review submissions and recommendations made by the Provincial Mental Health Advisory Council from its inception to date.

(b) Review relevant legislation in the other nine Provinces of Canada.

(c) Receive submissions and meet with persons or groups having an interest in the subject matter.

(d) Determine deadlines and acceptable format for submissions and determine all procedural matters for meetings.

(e) Report to the Minister, or his designate, in such a manner and at such times as determined by the Minister or the Chairman.

In giving the reason for the review, Mr. Bogle stated, "The Mental Health Act was introduced ten years ago and I believe it is timely to undertake a major reassessment of the legislation and practices used in Alberta, compare them with other jurisdictions and focus as appropriate on the society of today."

1.3 Members

The following persons were appointed as members of the Task Force:

Richard Drewry, Chairman, Edmonton

Mr. Drewry is an Edmonton lawyer engaged in private practice and has in the past served as the representative of the Law Society of Alberta on the Provincial Mental Health Advisory Council and has acted as Chairman of Review Panels.

Dr. Anthony Blunden, Edmonton

Dr. Blunden is a family physician practicing in Edmonton, having a particular interest in the problems of the chronically ill and of the elderly. He has served on the Provincial Mental Health Advisory Council both as a member at large and as a representative of the College of Physicians and Surgeons of Alberta. He is a member of the Alberta Medical Association Committee on Mental Health and active in the College of Family Physicians of Canada and was once President of the Alberta chapter of that organization. He is a member of the staff of the Royal Alexandra Hospital in Edmonton.

Dr. Paul Copus, Edmonton

Prior to coming to Edmonton in 1975, Dr. Copus worked as a consultant child and family psychiatrist in England. His first position in Edmonton was as a consultant psychiatrist with Regional Mental Health Services. Two years later, he established a private practice in Edmonton, having staff appointments at the University of Alberta Hospital and Misericordia Hospital in Edmonton. He served as a representative on the Provincial Mental Health Advisory Council from 1978 to 1981.

Miss Helen Hunley, Rocky Mountain House

Miss Hunley is currently Chairman of the Provincial Mental Health Advisory Council. Formerly, she was a business-woman in Rocky Mountain House and mayor of that community. She served as a member of the Legislative Assembly from 1971 to 1979, during which time she held several cabinet positions, including Minister without Portfolio, Solicitor General, and Minister of Social Services and Community Health.

Julius Johnson, Ponoka

Mr. Johnson practiced psychiatric nursing at Alberta Hospital, Ponoka from 1938 to 1976 and is now retired. He was a member of Alberta Hospital, Ponoka's accreditation committee in 1976 and served as Secretary to the Provincial Mental Health Advisory Council from 1976 to 1978.

Reverend D'Arcy Lade, Grande Prairie

Reverend Lade is Minister of Forbes Presbyterian Church in Grande Prairie, Alberta. Since the fall of 1981, he has served on the Peace River – Grande Prairie Regional Mental Health Council and is currently its vice-chairman.

Maurice Marsh, Taber

Mr. Marsh is currently employed in the oilwell servicing business. From 1955 to 1980, he was a member of the Royal Canadian Mounted Police, having served at detachments in Calgary, Brooks, Red Deer, Coronation, and Taber.

Donna Marshall, Calgary

Mrs. Marshall is a retired registered nurse. She has been active in numerous community and provincial activities for a number of years and is currently entering a second three-year term as a trustee on the Board of the Foothills Provincial General Hospital in Calgary. She is also serving on the Employee Relations Committee of the Alberta Hospital Association.

Margaret Shone, Edmonton

Mrs. Shone is an Edmonton lawyer employed with the Institute of Law Research and Reform. Her 1976 LL.M. thesis on compulsory civil commitment in Alberta has been widely quoted from and has been regarded as authoritative in Canada. She is Chairman of the Edmonton Regional

Mental Health Council and a member of the Provincial Mental Health Advisory Council. She is also a lecturer at the Faculty of Law, University of Alberta on law and psychiatry and a member of a variety of community organizations providing assistance to the mentally disordered.

The Task Force also employed a law student, Ms. Kristine Eidsvik, to perform legal research on a variety of topics under the direction of Mrs. Shone. Ms. Eidsvik is currently employed as an articled student at law in Edmonton.

1.4 Description of Mental Health Act

The Mental Health Act, R.S.A. 1980, c. M-13 as am. S.A. 1981, c. 72, gives the authority for the compulsory hospitalization of a person suffering from mental disorder who poses a danger to himself or others. The Act is divided into five parts.

1.4.1 General

Part 1 confers the powers necessary to enable the development of facilities, services and programs to give effect to the Act. Most of the administrative details are left to be filled in by the Minister of Social Services and Community Health and officials within the Department. More specifically, Part 1 provides for:

- the appointment of a Director and Associate Director and other employees of Mental Health Services (section 2)
- the establishment and operation of "places for the observation, examination, care, treatment, control and detention of persons suffering from mental disorder" (section 3)
- the delegation of powers and duties by a hospital board (section 4)
- the establishment of the Provincial Mental Health Advisory Council (section 5), regional mental health areas and Councils (section 6), and review panels (sections 7-10)

1.4.2 Admission to a Facility

Part 2 authorizes the compulsory examination and hospitalization of persons suffering from mental disorder.

The authority to compel examination and hospitalization is provided through physician certification and additionally, in emergency situations, by judicial order or apprehension by a peace officer. There are three types of certificates:

- conveyance and examination (sections 14-17)
- admission (sections 18-19)
- renewal (sections 20-21)

These sections specify who may issue the certificate, on what grounds, and with what effect. A person who has been apprehended pursuant to judicial order (section 22), or by a peace officer in the exercise of his power (section 23) is dealt with

thereafter as if a conveyance and examination certificate had been issued.

The above provisions apply to "civil" admissions. Compulsion for persons charged with a provincial or criminal offence is dealt with in Part 3 of the Act and includes a judge's order in respect of an accused person who is not in custody (section 35), a remand of an accused person to custody for observation under the Criminal Code (section 36(1)) and detention pursuant to Lieutenant Governor's warrant under the Criminal Code (section 36(2)).

Part 2 also sets out the duties of the hospital board in respect of admission and detention. They include the obligation to give reasons for a refusal to admit and permission to refer elsewhere (section 12); the duty to provide diagnostic and treatment services (section 13(1)); and the duty to determine the level of security that is reasonably required (section 13(2)). The Mental Health Act does not detract from the powers of a board under the Hospitals or any other Act (section 11).

1.4.3 Rights of Patients

Part 3 sets out the rights of patients once hospitalized. The sections cover the following topics:

- application to review panel for cancellation of admission or renewal certificates (section 24)
- proceedings before review panels (mode of application, notice of hearing, conduct of hearing, time and effect of hearing) (sections 25-28)
- application for transfer of convict back to a correctional institution (section 29)
- non-interference with mail (section 30)
- reception of visitors (section 31)
- appeal from decision of review panel to Court of Queen's Bench (section 32)
- discharge of patient (section 33)
- compliance with decision of review panel (section 34)
- confidentiality of diagnostic and treatment records (section 37)
- In addition to these sections dealing with the rights of patients, Part 3 includes the sections on compulsion in connection with a provincially charged offence or criminal proceeding (sections 35-36) and a section giving the hospital board the means of enforcing discharge (section 33).

1.4.4 Administrative

Part 4 confers administrative powers, for the care and control of involuntary patients and others thought to be in need of hospitalization, on the Director of Mental Health Services, a hospital board, and the medical director of a hospital. It pro-

vides for leave of absence (section 38); transfer to another facility inside (section 39) or outside Alberta; transfer for non-psychiatric hospital treatment (section 40); transfer of a patient into Alberta (section 41); and return of a patient, who leaves without permission, to a facility (section 43).

Part 4 also provides for the validation of documents which are defective in form (section 44), establishes liability for medical and maintenance expenses (sections 45-46) and gives the Lieutenant Governor in Council wide power to make regulations (section 47).

1.4.5 Mental Health Hospital Boards

Part 5 was added by the Mental Health Amendment Act, 1981, and proclaimed on 1 October 1982. It establishes as corporations Mental Health Hospital Boards, empowering them to administer the Alberta Hospitals at Edmonton and Ponoka. Prior to these amendments the two hospitals were administered directly by the provincial government.

The changes are modelled on the contents of the Provincial General Hospitals Act and the University of Alberta Hospital Act and are designed further to integrate "the treatment and care of mentally diseased persons into the mainstream of the health care system by having their hospitals administered" similarly to the provincial general hospitals (*Alberta Hansard,* November 3, 1981, at 1433, *per* Dr. Reid).

The amendments give hospital management a measure of independence from government. The boards are able to speak as political bodies, enabling the strengthening of hospital facilities and providing "leverage that is important to communicate the concerns, aspirations, and development of programs necessary within those hospitals" (*Ibid ., per* Mrs. Fyfe). Increased potential for flexibility in hospital management flows from the new independence. At the same time, immediate accountability for the running of the hospital falls to the Board instead of the government.

1.5 Methods of Study

In accordance with the instructions of the Minister, and to better conduct its review of the Mental Health Act, the Task Force employed a variety of methods of study: written submissions, public hearings, informal discussion, comparative research, and debate and deliberation.

1.5.1 Written Submissions

Advertisements were placed in newspapers throughout the province in March 1982 to invite the submission of written briefs on or before 31 October 1982. The advertisement appeared in 116 selected weekly newspapers, 10 Alberta daily newspapers, and 4 other publications. Invitations requesting

submissions were also sent to agencies and groups thought to be interested in the subject. These included all Alberta law enforcement agencies, professional and other associations, Indian reserves and Chiefs in Alberta, and individuals holding official positions or otherwise suggested to us. The deadline of 31 October 1982 was flexible and we took into consideration many submissions received after that date.

The Task Force was gratified by the large number of submissions received and their overall quality. A list of them can be found in Appendix "A".

1.5.2 Public Hearings

In the spring of 1983, public hearings were held in Grande Prairie (25 February 1983); Red Deer (16 March 1983); Lethbridge (7 April 1983); Medicine Hat (8 April 1983); Edmonton (11 May 1983); and Calgary (26 May 1983). Invitations to speak at the hearings were extended to every individual, group and association that had submitted a written brief. The meetings were also advertised to the public at large.

1.5.3 Informal Discussion

In addition to receiving formal briefs and hearing the presentations made at the public hearings, we made private inquiries and held informal discussions with a number of persons in order to educate ourselves as to the problems.

1.5.4 Comparative Research

From the outset, we held meetings for the purpose of educating ourselves to the issues we would confront. Our research assistant, Ms. Eidsvik, prepared separate study papers on six topics: Study Paper #1 – Definition of Criteria for Compulsory Civil Commitment; Study Paper #2 – Procedure for Confinement; Study Paper #3 – Inter-relationship Between the Mental Health Act, the Dependent Adults Act, the Emergency Medical Aid Act, the Public Trustee Act, the Child Welfare Act, and the Criminal Code of Canada; Study Paper #4 – Review Procedures; Study Paper #5 – Rights of the Hospitalized; and Study Paper #6 – Confidentiality of Medical Records.

The study papers compared provisions in progressive legislation in the jurisdictions of Ontario, Nova Scotia, England and California. In addition, the Task Force had access to a large body of literature on mental health concerns in Canada and foreign nations, periodical literature of a general reference nature and statistics on involuntary and voluntary admissions to Alberta Hospital, Edmonton and Alberta Hospital, Ponoka.

1.5.5 Debate and Deliberation

From July through September 1983 we held an intensive series of meetings for the purpose of developing the recommendations contained in this Report. These recommendations are based on the matters raised in the written submissions, or

brought to our attention by individuals with whom we met at regular meetings or from inquiries which we made between meetings, or from those highlighted in our independent background and comparative research work.

1.6 Scope

Many of the submissions to the Task Force made suggestions for the improvement of mental health services and care. These are discussed in 2.2 Emphasis on Community-Based Services.

We are sympathetic to many of the concerns expressed for we believe that the system of mental health service delivery could be much improved. We are well aware, moreover, that significant improvements to the mental health system cannot be achieved by legislation alone. Clearly, a major effort must be made to expand facilities.

We do not, however, see it as within our mandate to make proposals about these matters. For the most part, we have confined ourselves to matters which lend themselves to legislative reform and have refrained from making recommendations to meet service needs. Our primary objective in this Report, then, is to recommend improvements in the legal framework provided by the Mental Health Act for the care and treatment of persons suffering severely from mental disorder.

The Task Force was instructed not to undertake the drafting of legislation. We have tried to articulate our ideas with precision. Generally, the language used will require the refining touch of legislative counsel. Because of limitations of time and resources, in many instances we have left the contents of regulations under the legislation to development by appropriate government agencies.

1.7 Organization of Report

The sections and headings of this report derive from our use of the existing Mental Health Act as a guideline.

The initial portion of the report contains a brief resume of the existing provisions of the Mental Health Act. This is followed by a summary of provisions in the Canadian Charter of Rights and Freedoms which we believe will have a very serious impact on mental health legislation and which create a requirement that certain substantive and procedural civil rights be observed, all of which are discussed later on in the report.

We then tackle the major portion of the existing legislation, namely, the concept of compulsory hospitalization and all practices and procedures relating thereto. This is really the essence of the existing legislation, which does not so much govern "mental health" in this province as it governs the treatment of those who suffer from such severe mental disorders that they may be compulsorily treated. The latter cannot be avoided as being the basis of the Act. However, there is lengthy discussion in this part of the report and later in the sections dealing with children and adolescents of the need for proper treatment facilities as

a necessary precondition to any decent mental health delivery system and legislation.

The final portions of the report deal with treatment of patients while hospitalized. This has been and will likely always continue to be an area of major controversy. Many problems can be solved by proper legislation but, unfortunately, there are some problems which we believe have no current solution. The same can be said with respect to the questions surrounding patient records. The documentation of patient mental health information is potentially explosive unless confidentiality is maintained. There must be exceptions to confidentiality and we attempt to examine these in detail.

While the Task Force views the medical and, preferably, psychiatric professions as playing the leading role in hospitalization for mental health problems, we are also cognizant of a substantial contribution being made by other professions engaged in mental health care, and of the potential for even greater contribution by such persons. We have in mind clinical psychologists, psychiatric nurses, public health nurses, social workers, occupational therapists, and so on. The knowledge of these professions and the standards employed by them appear to be increasing at all times and, faced with an almost perpetual shortage of psychiatrists and spiraling costs of care, it is apparent that expanded roles for these professions will have to continue to be examined.

II. BASIC PREMISES

2.1 Meaning of "Mental Disorder"

Mental disorder potentially touches the lives of persons in all segments of society: the wealthy, the poor; children, the elderly; urban dwellers, rural residents; men, women; the highly educated and the illiterate; the black, white and red. Its effects range from minor dysfunction to total disability, from catatonic withdrawal to raging violence, from distortion of reality caused by fixed delusions to hallucinations.

Statistics Canada data published in 1981 in collaboration with the Canadian Mental Health Association, and based on data for the year 1978 states:

- It has been estimated that one of every eight Canadians can expect to be hospitalized for a mental illness at least once during his or her lifetime.
- Suicide was the second most frequent cause of death among Canadians between the ages of 15 and 39.
- Mental illness was the second leading category in general hospital use among those aged 20-44, exceeded only by accidents among men and pregnancy among women.
- Between 10% and 30% of the population have some form of mental illness, depending on the perceptions and definitions of the various disorders in this group.
- Compulsory hospitalization under legislative acts accounted for more than one-third of admissions to mental hospitals.

Many disorders are manageable with medications (chemotherapy) which have become increasingly specific and refined over the years. Others respond to verbal explorations (psychotherapy), punishment and reward systems of training (behavioural modification) and a host of other treatment techniques which may be used singly or in concert with endless variations for individual effectiveness. Professionals and other persons provide a wide range of specialized services as they participate in the care and treatment of the mentally ill through community services and hospitalization.

Needless to say, "mental disorder" is not easily defined. It embraces illnesses of the mind which impair reasoning, judgment and behaviour.

Insofar as compulsory hospitalization is concerned, the description of the patient given in the preamble to the submission of the Alberta Psychiatric Association is instructive. That group states:

> It must also be recognised very clearly that the patients about whom we are talking are an extremely disadvantaged group. This disadvantage lies not in their financial status, although many are poor, but rather in the fact that by all indices, social, intellectual and emotional these are a group of patients who have often had a poor social adjustment pre-morbidly, and who, when released from the hospital in many instances continue a similar poor adjustment. We are not dealing with the worried well. The anxious housewife seek-

ing future career directions is, notwithstanding the exaggerations of some of the legal commentators writing about certification, unlikely to find herself involuntarily hospitalized in any system. Our patients are all sick, often sick physically as well as mentally. When the acute phase has recovered, there often remains ongoing defects, which compromise social judgement, social skills and normal emotional responsiveness.

We will have more to say about the definition of mental disorder later. (See Chapter V. Criteria Justifying Compulsory Hospitalization.)

2.2 Emphasis on Community-Based Services

In submission after submission, groups stressed the importance of a system of service delivery which is based in the community. They repeatedly lamented the inadequacy of the services and the lack of facilities now available to meet the needs of persons suffering from mental disorder. They urged us to recommend that the improvement of the mental health delivery system should become a government priority.

The lament is not a new one. In 1969 the *Blair Report* (W.R.N. Blair, *Mental Health in Alberta: A Report on the Alberta Mental Health Study, 1968,* commissioned by the Government of Alberta, Executive Council, Human Resources Research and Development) proposed the establishment of services at the community level in conjunction with the movement of patients out of the remote provincial institutions. It has been widely observed that the number of beds in provincial psychiatric hospitals has decreased dramatically in the last decade or more while the building of community resources to take the place of institutional beds has not increased proportionately.

The concept of "deinstitutionalization" means more than the emptying of hospital beds. It means rendering assistance and care to the mentally disordered person in his home surroundings. It denotes a change in attitude toward treatment which emphasizes: (1) the importance of continued contact with the community; (2) the encouragement of as much autonomy for the patient as is possible (including his participation in decisions concerning him); and (3) facilitation of the re-entrance of a patient into the community. Hospitalization should be a last resort.

It is no revelation that the greatest shortcomings in the area of mental health in Alberta stem from the absence of an adequate service delivery system, not from the legislation. The need to improve community services has been much studied in recent years and proposals springing from the community have been made to the government on more than one occasion. Two recent examples of major significance are:

(1) **The Challenge for Psychiatric Care in Edmonton and Northern Alberta – An Action Program for the 1980's,** November 1980, commissioned by the Edmonton Hospitals Psychiatric Study Committee and conducted by McKinsey and Company of Toronto (hereinafter "the McKinsey Report"); and

(2) **Southern Alberta Study of Psychiatric Needs and Provisions,** Jan-

uary 1983, commissioned by the Southern Alberta Psychiatric Services Committee and conducted by the Consulting Group of the Clarke Institute of Psychiatry of Toronto (hereinafter "the Clarke Institute Report").

The Task Force does not view these matters as falling within our mandate. Nor do we feel qualified to make detailed proposals about them. We do, however, go as far as to endorse the notion that community-based services for the care and treatment of mentally disordered persons are to be preferred to institutionalization. We think it is desirable wherever possible to treat the patient at home in a familiar environment where local professionals, family members and friends can be involved. Our recommendations contemplate the establishment of facilities in local communities for detention, observation and compulsory examination under the Act.

We would also encourage the government to give earnest consideration to the recommendations contained in the reports mentioned above and in other submissions which it has received in recent years, and to embark on a course of expeditious implementation. To this end, we recommend that the Minister should have a legislative obligation to establish and maintain a satisfactory system of community-based mental health services (see 6.3 and 21.2.4).

2.3 Balance Between Interests of Society and Interests of Individual Suffering From Mental Disorder

Generally speaking, each individual in our society may make his own choices about medical care, place of abode and lifestyle without undue interference by the state. At the same time family and community members should be free from unconscionable harassment and harm. Society at large also has an interest in the well-being of each of its members and that interest includes the adequate and effective treatment of its sick members.

In some instances it is appropriate for the broader interests of the community to take precedence over the wishes of an individual within the community. Intervention against the will of a mentally disordered person may be justifiable in the best interests of society and of the suffering individual himself.

When intervention occurs it should be the least restrictive required to meet the problem, taking into consideration the availability and sufficiency of alternatives.

Safeguards to prevent abuse must attend the power of intervention. The Canadian Charter of Rights and Freedoms enacted on 17 April 1982 guarantees minimal protection of the rights and freedoms of all persons in a free and democratic society. The Charter has significant ramifications for interference with the liberty of a member of society, and the Task Force has tried to adhere to its requirements in formulating recommendations.

2.4 Provision of Comprehensive Treatment

The Task Force believes that hospitalization contrary to the expressed or apparent will of a mentally disordered person cannot be justified unless the care and treatment provided is comprehensive and of high quality. No one should have second rate treatment imposed upon him against his wishes.

For the most part, within the medical hierarchy we believe that the best quality of treatment or supervision would be afforded by a psychiatrist. Without accepting it, we reproduce a statement from the submission of the Alberta Psychiatric Association:

> ... no-one except a fully qualified psychiatrist has received the total rigorous training necessary to assess all the physiological, biochemical, hormonal, social, psychological, neuroanatomical and neuropharmacological factors which might be important in diagnosing mental disease, in identifying potentially lethal underlying physical causes for the illness, and in planning a comprehensive programme of the medical, psychological and social treatments that may be necessary in varying amounts to provide a specific treatment program for the individual patient.

At the very least, this statement points out the complex interrelationship of factors which can have a bearing on the identification of mental illness and the significance of the medically detectable components.

High quality treatment implies something more and that is the care and treatment of involuntary patients within the community where appropriate. The justification for community care from a therapeutic point of view should not have to be repeated. The trend in this direction is developing throughout the modern world. In this province it was advocated in the Blair Report and continues to be recommended in the McKinsey and Clarke Institute Reports referred to above (see 2.2).

Wherever possible, alternatives less restrictive than compulsory hospitalization should be pursued. Intervention by the state should be the final option. Where compulsory intervention is necessary, it should be the least restrictive required in the circumstances.

2.5 Position of Voluntary Patients

As a general principle, the Task Force looks upon voluntary patients as akin to any patient who agrees to undergo the treatment or treatments of an ailment, physical or mental. A voluntary psychiatric patient should have the same rights as a voluntary patient in any hospital service. If he is unhappy with his treatment in the hospital, or with the medical attention he is receiving, he can leave the hospital, change physicians, or decline care all together. We invoke this principle in general, but recommend some exceptions to it in the course of this report. For example, we believe that a voluntary mental patient should have the express right to clarification of his status as a voluntary patient at any and all times.

2.6 Limitations of Legislation

As a general statement, it is wise to remember that there are limits upon the ability of legislation to resolve social problems. This is especially true in the case of care for the mentally ill.

The Task Force has attempted to avoid recommending legislation that would be nonfunctional or ineffectual.

On many issues, we adopt the position that the answers must come from improvements in administration and practice. One example is our attitude toward legislation to require the establishment of treatment and discharge plans. They are, no doubt, to be encouraged as a matter of good medical practice, but we do not believe that the imposition of a legislative duty to prepare such plans would significantly alter existing practices. If the attitude of mental health personnel is wrong, the treatment and discharge plans made simply to satisfy the legislative directives are likely to be perfunctory and ineffectual; similarly, if staff shortages impair the development of good health care practices, the legislative burden is unlikely to be met because more urgent demands will take precedence.

A second example is our attitude toward a legislative requirement making cancellation of certificates mandatory when the condition of the patient remits to the point that he could not have been certified in the first place. The imposition of controls on an on-going basis is not feasible but the right to periodic review of the certificates can help.

A third example is our attitude toward legislation to regulate apprehensions by a peace officer. It would be desirable for the officer to wear plain clothes, and drive an unmarked car, and for a physician to come with him. Circumstances, however, will not always permit attention to these details. Legislation would be inappropriate.

III. COMPULSORY HOSPITALIZATION – THE SCENE

A person experiencing mental health problems may seek the aid of family, friends, a mental health worker, a physician or other counselling agency. Should his condition deteriorate or a crisis arise, he may be willing to be hospitalized in a hospital close by in order to receive psychiatric attention. His judgment may, on the other hand, be clouded by reason of illness such that he does not appreciate his need for medical treatment in a hospital. The fact that this is his condition must be determined. The urgency of situations varies. It is at this point, nevertheless, that the question arises: what circumstances justify authoritative intervention contrary to the wishes of the individual?

The consideration of issues pertaining to intervention occupies the greater part of the remainder of this report.

IV. THE CHARTER OF RIGHTS

4.1 General

The Canadian Charter of Rights and Freedoms (hereinafter "the Charter") was enacted as Schedule B to the *Canada Act* (U.K.) 1982, c. 11, which came into force on 17 April 1982. Because the rights and freedoms set out in it are constitutionally entrenched, the Charter is destined greatly to change the face of Canadian jurisprudence.

We think that the Charter will have an important impact on mental health legislation authorizing compulsory hospitalization and treatment. Canadian jurisprudence interpreting the Charter is beginning to emerge but the authorities are mainly in the lower courts and they vary a great deal.

In trying to predict the impact of the Charter, therefore, we have looked at decisions interpreting analogous provisions in the Constitution of the United States (hereinafter "the U.S. Constitution"), and of the European Convention for the Protection of Human Rights and Fundamental Freedoms (hereinafter "the European Convention").

We introduce the relevant sections of the Charter in this chapter, leaving detailed discussion to subsequent chapters, as appropriate.

4.1.1 Limitations Clause: Section 1

> The Canadian Charter of Rights and Freedoms guarantees the rights and freedoms set out in it subject only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society.

Section 1, popularly called the "limitation clause", sets the framework for the interpretation of the Charter. "Law" includes statute and common law. The reference to a "free and democratic society" supervenes the notion of Parliamentary sovereignty, in that some principles are accorded higher credence than the views enunciated by the government of the day. Legislators carry the onus of demonstrably justifying action seeking to limit rights. Professor T. Christian ("The Limitation of Liberty" (1982) U.B.C. Law Rev., Charter Edition, 105) suggests that legislation curtailing rights must be rationally connected to the attainment of a legitimate state object and no more excessive than is necessary for the attainment of that object. Moreover, it cannot be arbitrary, capricious nor motivated by bad faith.

4.1.2 Charter Not Exhaustive: Section 26

> The guarantee in this Charter of certain rights and freedoms shall not be construed as denying the existence of any other rights or freedoms that exist in Canada.

Section 26 clarifies that the Charter is not comprehensive and exhaustive of all rights and freedoms that exist in Canada. Such

rights may exist outside of the Charter or be inferred from a reading of the Charter provisions in combination.

4.1.3 Opting Out: Section 33

(1) Parliament or the legislature of a province may expressly declare in an Act of Parliament or of the legislature, as the case may be, that the Act or a provision thereof shall operate notwithstanding a provision included in section 2 or sections 7 to 15 of this Charter.

(2) An Act or a provision of an Act in respect of which a declaration made under this section is in effect shall have such operation as it would have but for the provision of this Charter referred to in the declaration.

(3) A declaration made under subsection (1) shall cease to have effect five years after it comes into force or on such earlier date as may be specified in the declaration.

(4) Parliament or the legislature of a province may re-enact a declaration made under subsection (1).

(5) Subsection (3) applies in respect of a re-enactment made under subsection (4).

The legislature of a province wishing to avoid the rigors of the Charter may resort to section 33 to validate, by express declaration, an Act or provision in an Act that otherwise infringes section 2 or sections 7 to 15. To remain in force the declaration must be re-enacted every five years.

The Task Force neither recommends, nor anticipates, the use of section 33 in connection with hospital commitment legislation.

4.1.4 Enforcement of Rights: Section 24(1)

Anyone whose rights or freedoms, as guaranteed by this Charter, have been infringed or denied may apply to a court of competent jurisdiction to obtain such remedy as the court considers appropriate and just in the circumstances.

Section 24(1) supplies the remedy for enforcement of the Charter by a person whose rights have been directly affected by its breach.

4.1.5 Supremacy of Charter: Section 52(1)

The Constitution of Canada is the supreme law of Canada, and any law that is inconsistent with the provisions of the Constitution is, to the extent of the inconsistency, of no force or effect.

Section 52(1) declares the primacy of the Constitution of Canada such that the Charter will prevail over other laws if they are inconsistent.

The constitutionality of the other laws may be challenged not only by a person whose rights or freedoms are directly affected but also, in the discretion of the court, by a citizen who has a general interest in the validity of the legislation.

4.2 Fundamental Freedoms: Section 2

Everyone has the following fundamental freedoms:

(a) freedom of conscience and religions;

(b) freedom of thought, belief, opinion and expression, including freedom of the press and other media of communication;

(c) freedom of peaceful assembly; and

(d) freedom of association.

The exercise of many of the "fundamental freedoms" set out in section 2 will be curtailed by compulsory confinement for mental disorder but, pursuant to section 1, as long as the restrictions can be demonstrably justified in a free and democratic society they will not be unconstitutional.

4.3 Legal Rights

4.3.1 Right to Life, Liberty and Security of Person: Section 7

> Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice.

Section 7 of the Charter is of crucial importance to the formulation of laws authorizing involuntary hospitalization.

It is comparable to the 14th Amendment of the U.S. Constitution and Article 5(1)(e) of the European Convention.

The 14th Amendment provides that no state shall "deprive a person of.. liberty.. without due process of law."

Article 5(1) of the European Convention reads:

> Everyone has the right to liberty and security of the person. No one shall be deprived of his liberty save in the following circumstances and in accordance with a procedure prescribed by law ...
>
> (e) the lawful detention.. of persons of unsound mind...

Meaning of "life, liberty and security of the person"

It is likely to be found that the detention of a person under the authority of the Mental Health Act deprives him of his liberty and of his security. Both words embrace concepts which extend beyond mere bodily or physical liberty and security to incor-

porate notions of the psychological and emotional well-being of the individual.

Liberty. Mr. Justice Douglas of the United States Supreme Court recently elaborated upon the meaning of liberty in the 14th Amendment, saying:

1) First is the autonomous control over the development and expression of one's intellect, interests, tastes and personality.

2) Second is freedom of choice in the basic decisions of one's life respecting marriage, divorce, procreation, contraception and the education and upbringing of children.

3) Third is the freedom to care for one's health and freedom from bodily restraint or compulsion, freedom to walk, stroll, or loaf.

Doe v. *Bolton* (1973) 93 S.Ct. 705.

Security. Two centuries ago, in his famous lectures on English law, Sir William Blackstone identified a "right to personal security" which "consists in a person's legal and uninterrupted enjoyment of his life, his limbs, his body, his health, and his reputation" (Commentaries on the Laws of England, Bk. I at 129).

Meaning of "fundamental justice"

Procedural justice. In interpreting the language of section 2(e) of the Canadian Bill of Rights, predecessor to section 7 of the Charter, the Supreme of Court of Canada said in *Duke* v. *The Queen,* [1972] S.C.R. 917, 28 D.L.R. (3d) 129 at 134:

> ... the tribunal which adjudicates upon his rights must act fairly, in good faith, without bias and in a judicial temper, and must give to him the opportunity to adequately state his case.

An opportunity to be heard, and an impartial tribunal, are the traditional arms of procedural fairness guaranteed by the principles of natural justice at common law. The reference, then, to the principles of "fundamental justice" is a reference at least to procedural fairness.

Substantive justice. The "due process" clause in the U.S. Constitution and Article 5(1)(e) of the European Convention have both been interpreted to import the broader notion of substantive justice. The European Court of Human Rights has twice held that Article 5(1)(e) demands not only formal but also substantive justification for lawful detention: both the procedures bringing about the deprivation of liberty and its continuance, and the criteria upon which the deprivation is based must be fair (*Winterwerp* v. *Netherlands,* 2 E.H.R.R. 387, para. 39; *X* v. *United Kingdom,* 4 E.H.R.R. 188).

The "principles of fundamental justice" referred to in section 7 of the Charter may possibly introduce the concept of substantive fairness into Canadian constitutional law.

4.3.2 No Unreasonable Search and Seizure: Section 8

> Everyone has the right to be secure against unreasonable search or seizure.

A patient who experiences undue interference with his person or private possessions may be protected by this section.

4.3.3 No Arbitrary Detention or Imprisonment: Section 9

> Everyone has the right not to be arbitrarily detained or imprisoned.

If the principles of fundamental justice are met as is required by section 7, then the detention will not be arbitrary; it will be the consequence of the operation of law including fair process. For example, the failure of the hospital to cancel certificates when the condition remits may be an infringement.

4.3.4 Rights on Arrest or Detention: Section 10

Everyone has the right on arrest or detention

(a) to be informed promptly of the reasons therefor;

(b) to retain and instruct counsel without delay and to be informed of that right; and

(c) to have the validity of the detention determined by way of *habeas corpus* and to be released if the detention is not lawful.

These paragraphs have implications for the process to be followed in compulsory hospitalization, notification to the patient of the reasons for the certification and of his right to retain and instruct counsel, and the possibility of challenging the detention.

4.3.5 No Cruel or Unusual Punishment: Section 12

> Everyone has the right not to be subjected to any cruel and unusual treatment or punishment.

This section parallels the 8th Amendment to the U.S. Constitution. Through it, the American courts have struck down some of the more offensive types of punishment such as corporal punishment and solitary confinement. Although the section is usually used in connection with prisoners, it has also been used with regard to psychiatric patients being given involuntary treatment.

4.3.6 Right to Assistance of Interpreter: Section 14

A party or witness in any proceedings who does not understand or speak the language in which the proceedings are conducted or who is deaf has the right to the assistance of an interpreter.

The Mental Health Act now provides in section 24(2) for the provision of a suitable interpreter in the event of language difficulties for the purpose of informing the patient under certificates and his nearest relative of the reason for their issuance and supplying a written statement of the authority for the detention and of the right to review. There is no mention of the provision of an interpreter during the hearing itself. The rights set out in the Act will have to be extended.

4.4 Equality Rights: Section 15

(1) Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.

(2) Subsection (1) does not preclude any law, program or activity that has as its object the amelioration of conditions of disadvantaged individuals or groups including those that are disadvantaged because of race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.

Section 15 is subject to a 3-year delay so that its "Charter Day" will be 17 April 1985. It is relevant to the enjoyment of ordinary civil rights by mentally disordered persons who are guaranteed a status equal to that of other persons. In particular, it elevates the rights of the mentally disabled to the same standing as the physically disabled with respect, for example, to employment at a job the person is capable of performing and to reasonable accommodation.

V. CRITERIA JUSTIFYING COMPULSORY HOSPITALIZATION

5.1 Introduction

Three criteria must be met for compulsory hospitalization under the Mental Health Act. A person must be found, upon medical examination, to be:

(a) suffering from mental disorder,

(b) in a condition presenting a danger to himself or others, and

(c) unsuitable for admission to a facility other than as a formal patient.

The existing criteria are fairly open-ended. Several submitters wanted more specific criteria; others were content to leave the existing criteria alone. Open-ended criteria invite diverse rather than uniform interpretations, making it difficult for family, friends, mental health professionals and others to predict when certificates authorizing compulsory hospitalization will be issued. It is desirable, on the other hand, to leave room for the exercise of medical judgment about the need for compulsory intervention in an individual case.

Penrose's law expresses an inverse relationship between jail and mental hospital populations: the more prohibitive the criteria for compulsory hospitalization the greater the likelihood of the persons excluded gravitating to the prison system.

In the following pages we recommend a more precise definition of "mental disorder" and the rewording of the requirement that the person be "unsuitable for admission other than as a formal patient". We do not think that other useful improvements can be made and recommend that the criteria should otherwise remain unchanged.

One word about terminology. The Mental Health Act uses the words "formal patient" to describe a person hospitalized against his will. The description is euphemistic. We prefer the words "involuntary patient". They describe the patient's status more clearly and are consistent with the correlative expression "voluntary patient".

5.2 Charter Implications

If section 7 of the Charter is interpreted to include substantive justice (see meaning of "fundamental justice" under 4.3.1), it will have implications for the grounds for compulsory hospitalization. The European Court of Human Rights held in the *Winterwerp* case, and reconfirmed in the *X* case, that for the detention to be lawful three criteria must be fulfilled: (1) a true mental disorder (mental illness or personality disorder) must be established before a competent authority on the basis of objective and reliable medical expertise; (2) the mental disorder must be of a kind or degree sufficiently serious to warrant compulsory confinement, mere nonconformist or abnormal behaviour being insufficient; and (3) the validity of the continued confinement depends on the persistence of such a disorder.

In the United States many courts dealing with state committal laws have ruled that the provisions of the 14th Amendment make it unconstitutional for a person to be civilly committed unless some form of danger criterion has been satisfied. The rationale adopted by the courts for this position is that the protection of members of the state, and of the individual from himself, are the only interests that can override the individual's rights to liberty and therefore be constitutional under the due process clause of the 14th Amendment.

In both the *Winterwerp* and *X* cases the European Court of Human Rights emphasized that the criteria which it laid down for compulsory hospitalization do not necessarily apply in cases of emergencies. In emergencies "the interests of the protection of the public prevail over the individual's right to liberty to the extent justifying the confinement" (*Winterwerp*, para. 45). In these circumstances it would be impracticable to require a thorough medical examination prior to the confinement and, as a result, a wide area of discretion must be conferred on the detaining authority (*X*, para. 41). (See discussion in Christopher Newdick, "Mental Health Patient's Rights and Ministerial Discretion" (1982), 45 Mod. L.R. 459 at 460.)

Case law in the United States is to the same effect. Short-term emergency confinement without a hearing probably would be tolerated in a free and democratic society provided that the opportunity for a hearing into the merits of detention follows promptly.

5.3 Criteria in the Existing Act (sections 18(1), 20(1))

5.3.1 Suffering From Mental Disorder

The presence of mental disorder is an essential prerequisite to compulsory hospitalization. The *Winterwerp* judgment requires the establishment of "a true mental disorder be it mental illness or a personality disorder.

Section 1(h) of the Mental Health Act defines "mental disorder" to mean lack of reason or lack of control of behaviour. As is observed in one submission, these words could encompass such behaviours as promiscuity, immoral conduct, alcoholism, drug addiction, or mental retardation without the existence of any mental disease.

The Task Force believes that the definition should be more precise. At the same time, it should not be excessively technical but should allow for the application of advances in knowledge concerning the identification and treatment of mental disorders. The definition should emphasize the severity of the condition. It should exclude mere social deviance. Mental retardation should enjoy a clear and continuing separation from mental illness.

We recommend the adoption of the definition used in Vermont, with one change (Vermont Statutes Annotated, T.18, s.

7101(14)). The Vermont language is simple and refers to the major areas of disorder. It describes mental disorder as:

> a substantial disorder of thought, mood, perception, orientation or memory, any of which grossly impairs judgment, behavior, capacity to recognize reality or ability to meet the ordinary demands of life but shall not include mental retardation.

We would reword the final clause to say "but shall include neither mental retardation nor a disorder which is restricted to the relationship between the individual and society". The additional words are borrowed from the Diagnostic and Statistical Manual of Psychiatric Disorders, 3rd ed., published by the American Psychiatric Association in 1980. Their purpose is to exclude disorders of social interaction and mere eccentricities in behaviour from the definition. They should not be read to exclude a psychopath who is also mentally ill (e.g. suffering from depression) from the ambit of the definition. Nor should the exclusion of "mental retardation" be read to except a person who is mentally retarded and mentally ill.

5.3.2 In a Condition Presenting a Danger to Himself or Others

The *Winterwerp* decision speaks of a mental disorder "of a kind or degree sufficiently serious to warrant compulsory confinement". American case law suggests the need for satisfaction of some form of "dangerousness" criterion. If section 7 of the Charter is interpreted to require substantial as well as procedural justice, "dangerousness" may have to be included as a criterion.

In any event, the sanctity of individual liberty has long been revered in our society and safeguards against undue intervention date as far back as the signing of the first Magna Carta in 1215. Nevertheless, the state has an obligation to protect members of society from danger posed by any of its members. This is the main traditional justification for the intrusion by the state into the private domain of a subject. The state also has a concern of long-standing recognition for the health of all members of society, including the health of a person whose lack of insight into his condition has so impaired his judgment that he denies the existence of mental disorder or its extent.

In the view of the Task Force a determination that a person poses a danger to himself or others is an appropriate criterion and it should be retained.

We make this recommendation despite three drawbacks in the use of dangerousness as a criterion:

(1) the meaning of dangerousness is not conceptually clear, but requires more precise definition;

(2) the potential dangerousness of any one person is not capable of accurate prediction; and

(3) the incidence of dangerous behavior in persons suffering from mental disorder is not greater than the incidence within society as a whole.

Meaning of Dangerousness

The meaning of dangerousness raises a number of questions. How serious must the "dangerous" conduct be? Is it to be measured by a criminal law standard of proof (beyond a reasonable doubt) or by a civil law standard (on a preponderance of the evidence)? Does it extend to verbal threats as well as physical violence? Does it embrace conduct toward property as well as persons? Does it encompass insidious behaviour or only overt acts? How likely is it to occur?

Other jurisdictions, for example Ontario, qualify the interpretation of dangerous with adjectives describing the degree of dangerousness (e.g. "serious"), its immediacy (e.g. "imminent"), and the type of harm (e.g. "physical" or "bodily"). Some studies indicate that the linguistic limitations make little difference to the admissions which actually take place. The statistics remain essentially unchanged.

The Task Force is wary of introducing legislative restrictions. We are not convinced that they alter practice significantly. Moreover, words of limitation may prevent intervention in circumstances where it would be appropriate. For example, where the behaviour of a mother suffering from paranoid delusions poses a danger of psychological harm to her young children, it may be better to hospitalize the mother than to remove the children from the home. The father may be able to care for the children in the absence of the mother. A second example of behaviour which may not fit within a limiting prescription is the threat of a psychiatrically ill husband to burn down the house in which his wife and children live.

We have concluded that it is best not to attempt to qualify the meaning of dangerousness. Instead, we would leave latitude for the exercise of professional discretion and clinical acumen by the physician or psychiatrist performing the examination.

Prediction of Dangerousness

There are no reliable clinical or other techniques to ascertain dangerousness in individual cases, making accurate predictions about persons without a history of having inflicted or attempted to inflict harm particularly difficult.

A study submitted to the Task Force by Dr. J.E. Arboleda-Florez and H.L. Holly indicates that Alberta psychiatrists are fairly confident of their ability to recognize those occasions when a person presents a danger to himself. They see the assessment of

dangerousness to others as a criterion which does not fall within the exclusive expertise of psychiatrists. They suggest the establishment of a panel composed of a psychiatrist, the closest next-of-kin and one other mental health specialist to make this determination.

Notwithstanding this reluctance, we regard psychiatrists as the most dependable social agents to predict dangerousness to others. They are conveniently on the staff. They are familiar with the behavioural problems of mental disorders. They are as able as any other member in society to assess the likelihood of dangerousness. Reliance on psychiatric opinion is expedient.

Incidence of Dangerousness in Mentally Disordered Persons

Using dangerousness as a criterion in conjunction with mental disorder may lead to the false assumption that the incidence of dangerous behaviour in persons suffering from mental disorder is greater than the incidence of dangerous behaviour within society as a whole. This assumption is not proven statistically. There is some evidence that the incidence of dangerous behavior in persons suffering from mental disorders is lower than in the general population.

We nevertheless endorse the inclusion of dangerousness as a criterion. Medical attention can bring about the abatement of dangerousness caused by mental disorder, whereas society does not have a proven means of reducing dangerousness which is not associated with a mental disorder.

Substitution of Language of "Safety" and "Protection" for Dangerousness

The British Mental Health Act 1959 (7 & 8 Eliz. 2, c. 72) does not make reference to "dangerousness". Instead, it speaks of a disorder or disability of the mind which warrants detention under observation in the interests of the person's own health and safety or with a view to the protection of others.

The adoption of this language in substitution for the criterion of dangerousness is advocated in some submissions. Although the use of these words avoids the problem of the unpredictably of dangerousness, it expands the umbrella of authorized compulsory hospitalization. It emphasizes the welfare of the patient and leads toward "in need of treatment" as a criterion.

We believe that a stronger justification must be made before intervention occurs.

5.3.3 Unsuitable For Admission to a Facility Other Than as a Formal Patient

The words "unsuitable for admission to a facility other than as a formal patient" infer that the person is either unable, because of the interference of the mental disorder with his thought processes, or unwilling to be hospitalized voluntarily. Where a

person recognizes his need to be hospitalized and agrees to it, compulsory intervention is inappropriate. That is to say, the person who is competent has the option of being hospitalized voluntarily. If he chooses to exercise it, certification will not take place. If he refuses to exercise it, or he is incompetent to consent, he may be certified provided the other two criteria (mental disorder and dangerousness) are satisfied.

We agree with what we understand to be the intent of this criterion. The language, however, does not clearly express the intent. We recommend the substitution of the words "incompetent to give a valid consent to treatment or, if competent, refuses to be hospitalized as a voluntary patient".

5.4 Other Criteria Considered

5.4.1 Competence to Consent to Medical Treatment

In ordinary circumstances a person who is competent may weigh the advantages and risks of accepting or refusing medical treatment and make his own decision, even if it means enduring bodily malfunction, pain or possible death. A person who is mentally disordered and dangerous may, nevertheless, have the requisite legal competence to make decisions about his medical treatment. Should his competence inhibit the power of the state to compel him to receive medical treatment?

It is arguable that state intervention to protect a person from himself only makes sense where he is unable to make his own decisions. A mentally disordered person who is competent should not be hospitalized against his will because a physician regards his decision as detrimental to his health.

It is also arguable that a person who is mentally disordered and dangerous to others, but competent, should not be hospitalized against his will. Many people in society are potentially dangerous but they are not incarcerated on the basis of prediction alone. Society requires infraction of the criminal law and a hearing in a court of law attended by stringent procedural safeguards before imprisonment. Discrimination on the basis of mental disorder is unjustifiable.

Intervention in the interests of society should be highly exceptional. Other examples where it is authorized in Alberta are the Venereal Diseases Protection Act, R.S.A. 1980, c. V-2, and the Tuberculosis Act, R.S.A. 1980, c. T-11. Provision is also made for medical intervention without the requisite consent in emergency situations (Emergency Medical Aid Act, R.S.A. 1980, c. E-9 as am. c. 7 (Supp.)).

We do not believe that the person's competence or incompetence should be a factor. A mentally ill person is sick and does not have the same power of reason and control over his behaviour as does a sane person. We think that compulsory hospi-

talization is justified both in the interests of the individual and of society. This is a case where the interests of the community override the wishes of the individual.

The Task Force does not endorse the inclusion of incompetence among the criteria for involuntary commitment to hospital.

5.4.2 Need for Treatment

The criterion "in need of treatment" is usually linked with the presence of mental disorder and substituted for the criterion of dangerousness. If "dangerousness" is a necessary criterion under the Charter, talk of a person who is "in need of treatment" will not be enough.

The Task Force appreciates the desire of members of the medical and other helping professions to improve a person's condition or help to alleviate suffering. We are also sympathetic to the concerns of relatives who suffer considerable stress as a result of a family member's illness.

In our view, however, legislative authority to intrude against the will of the individual should be cautiously undertaken. There are many individuals in society who might benefit from treatment of one kind or another (e.g. a heavy smoker, a heart attack risk), yet society does not impose treatment on them against their will.

We do not believe that society should take away a mentally disordered person's power of autonomous decision-making and liberty on the basis of his need for treatment without more substantial criteria. We do not, therefore, recommend the inclusion of this criterion.

5.4.3 Treatability

Is society ever justified in taking away the liberty of a person who satisfies the criteria but is not treatable?

What constitutes treatment and, consequently, what amounts to treatability are moot questions. One test of treatability is whether the treatment is likely to alleviate, or prevent deterioration in, a person's condition. This gives broad latitude. Treatment could be as basic as improving the person's hygiene, nutrition and shelter.

There is a small nucleus of patients whose condition is such that they will never be restored to autonomous functioning. The group includes persons with chronic brain damage, perhaps as a result of a motor vehicle accident or a stroke, who are impulsive, violent or otherwise seriously disruptive. It also includes persons caught up in the revolving door syndrome. These are persons whose condition improves with hospital care but who deteriorate upon discharge into the community. When on the street, they tend to congregate in the "inner city". They are jobless, living in substandard accommodation on poorly

managed social assistance monies, and are generally unable to cope adequately with everyday life. Some become derelict and gravitate to the penal system. There is a strong argument for providing long-term shelter and support, literally "asylum", to persons in these straits.

The Task Force does not believe that a person's treatability should affect the decision to hospitalize him involuntarily. As we have said, the broader interests of the community, both in its own safety and in the welfare of individuals within it, must sometimes take precedence.

VI. DESIGNATION OF FACILITIES

6.1 Shortage of Existing Facilities

Only Alberta Hospital, Edmonton and Alberta Hospital, Ponoka function as facilities for all purposes under the existing Mental Health Act (that is, for the admission of patients who receive and meet the criteria for intervention). The Foothills Provincial General Hospital, Calgary; the Holy Cross Hospital, Calgary; and the Calgary General Hospital operate as facilities for the limited purpose of examination under the authority of a conveyance and examination certificate (section 14).

Four other hospitals designated as facilities for all purposes seem unable to fulfill the role because of inadequate physical accommodation, lack of sufficiently qualified staff, or both. They are: Taber General and Auxiliary Hospital; Lac La Biche General Hospital; Canadian Forces Hospital, Cold Lake; and Pincher Creek Municipal Hospital. One of these hospitals reputedly accepted the status so that persons in the area would not have to be driven to Calgary, Ponoka or Edmonton for a compulsory examination.

The absence of facilities in locations throughout the province constituted the largest single cause for complaint which the Task Force encountered in the submissions and at the public hearings. A person who is apprehended pursuant to judicial warrant (section 22) or the peace officer's power (section 23) often must be conveyed a considerable distance from his home for an examination by a physician to ascertain his medical condition. The dislocation is inconvenient and non-therapeutic. Police complain that too much time is spent in police custody before medical attention is received. The person may be held in a police cell until conveyance can be arranged. The transportation is costly and represents an inefficient use of police skills and time. Even where the conveyance is authorized by a certificate issued by a physician, a person may be turned away from an Alberta hospital because, in the opinion of the examining physician on the staff of the facility, he does not meet the criteria for compulsory intervention. We have listened to enough tales from a sufficient variety of sources to be persuaded that dispositions at the doors of these hospitals are not uniformly satisfactory.

Nor is the situation wholly satisfactory where the patient is admitted for treatment. The patient, by definition the most severely afflicted of those suffering from mental disorder and most needing the support of family, friends and other resources familiar to him in his home community, is abruptly uprooted and separated from them by the many miles inbetween. Branded as a patient in a "mental hospital", he faces possible stigmatization, job loss, disruption of accommodation, removal of his personal belongings, impairment of future employment prospects, and general difficulty reassimilating into the community.

6.2 Proposal For Three Levels of Facility

To meet the problem, the Task Force proposes the implementation of a three-level gradation of designated facilities ("DF's"): the first for short-term observation and assessment within the local community (DF1); the second for medium-length periods of hospitalization within the regional

mental health area (DF2); and the third for extended stays at provincial psychiatric facilities (DF3). The paragraphs which follow describe our conception of each level of facility in general terms.

The approach bespeaks the principle of the least restrictive alternative, and conforms to our belief that the patient should be managed in a facility close to home wherever possible. The Task Force sees many advantages. The person will be able to stay in close contact with family, friends, his solicitor, and other sources of support known to him within the community. He can be easily visited. Telephone communication will not entail long distance charges. Stigmatization is likely to be reduced. When the patient is ready to be discharged, follow-up arrangements can be more readily handled through personal contact with agencies near at hand, or the hospital may have its own out-patient program which the patient could commence attending. Using local and regional facilities should also help to relieve the shortages of bed space at the two Alberta Hospitals.

6.2.1 DF1: Observation and Assessment Facility

The purpose of a DF1 is to provide an opportunity for the initial observation and assessment including examination of a patient who could be detained for this purpose for up to 96 hours. DF1's should be located in smaller centres throughout the province. We imagine a hospital with a total capacity of 30 to 60 beds.

The hospital will need to be able to respond to the needs of patients in violent, disruptive or suicidal states. For this purpose the facility should have a physically secure segregated area, perhaps a single room with unbreakable windows allowing for easy observation from the nursing station.

It should also have available on duty or on call at least one staff physician, preferably a physician with some experience with mental disorders. He would prescribe emergency or other essential medication and conduct a medical examination to determine whether the patient should be involuntarily hospitalized in a DF2. Ideally, a psychiatrist would be available to be called on for consultation. The capacity for psychiatric supervision could be expanded by the use of the phone or by the use of a video linkup with a university unit where such supervision cannot be conducted in person for the purpose of examination and assessment of the person under detention. Experienced nurses must be able to observe and record the behaviour of persons in the facility; give necessary care and attention, including round-the-clock supervision if required; and carry out other physician's orders. Every effort should be made to employ nurses with psychiatric training or qualifications. A co-operative arrangement might be made with local police to assist in the control of particularly violent persons.

Holding beds in a suitably staffed and physically secure setting in an out-patient unit or community mental health clinic could be designed to serve the same function.

Upon examination and assessment, a person who satisfies the criteria for the issue of a certificate authorizing further detention will be moved on to a DF2 or DF3. The short-term observation period may serve to calm a person sufficiently so that he no longer requires compulsory medical attention. If for this or any other reason he does not satisfy the criteria for certification, he will be returned to the community. Alternatively, he may come to realize his need for treatment and accept it on a voluntary basis.

6.2.2 DF2: Regional Psychiatric Facility

The DF2 is designed for the hospitalization of patients under dual medical certificates for up to 28 days. There should be at least one DF2 in each of the six regional mental health areas established within the province.

A DF2 should have the potential to offer more sophisticated care than a DF1. The Task Force envisages a fully developed psychiatric ward in a larger hospital within the region in which the individual resides. We believe that on such wards staffing patterns and modern therapeutic methods are adequate, on the whole, for the management of the involuntary patient. A DF2 should have all of the capacities of a DF1 including a secure area staffed by suitably qualified personnel in sufficient numbers to manage difficult patients and to give competent supervision where this is required. It should have the additional capacity to care for and treat the patient on an intermediate basis. It should offer good therapeutic programs including outpatient or follow-up services.

The restriction of the function of a DF2 to medium-stay hospitalization for no more than 28 days should ensure that community beds do not become congested. Statistics for the year 1981 at Alberta Hospital, Edmonton indicate that of the patient population during that year 22.8% of patients were discharged in less than two weeks, and 30.2% more were discharged in from three to four weeks. In all, 53% of patients admitted were discharged within 28 days. We chose our recommended time periods on the basis of these statistics.

The Task Force postulates that a high percentage of the patients admitted on certificates to a DF2 will be discharged within 28 days. We predict that some of the remaining patients will have accepted hospitalization on a voluntary basis by this time. Those patients still in hospital and who, upon examination, are found to require longer term involuntary hospitalization would be transferred to a DF3.

6.2.3 DF3: Provincial Psychiatric Facility

The DF3 should provide the most sophisticated psychiatric care available for those patients whose illnesses are the most severe or chronic. It would be the last resort when less extreme interventions have proven unworkable. In addition to offering long-

term rehabilitation programs for cases of severe chronicity, the DF3 might serve to treat persons suffering illness of a specialized type such as chronic brain damage or psychogeriatric ailments. They should be reserved for use when all other facilities in the community have failed in their efforts to help the patient.

The length of stay of a patient hospitalized under certificate would be unlimited, although periodic reassessment would be required.

The Task Force anticipates that the function would be fulfilled by hospitals like Alberta Hospital, Edmonton and Alberta Hospital, Ponoka. The facilities should have on staff psychiatrists (preferably with Canadian qualification), physicians, nurses and other support staff in an adequate staff-patient ratio to meet the needs of the patient population. They should have the best equipment available for diagnosis and treatment and should offer a wide range of programs, including out-patient or follow-up services and links with community agencies.

6.2.4 Multiple Designations

The designations of DF1, DF2, and DF3 are designations of function. Designation for one function should not preclude designation for another. For example, a hospital designated as a DF2 might also be designated locally as a DF1. Or, a hospital designated as a DF3 might also be designated to serve as a DF2 within its region and even as a local DF1.

6.3 Responsibility For Establishing Facilities

The establishment of adequate facilities at each level, throughout the province, is imperative to a well-functioning system capable of responding to the needs of severely mentally disordered persons. This point cannot be overemphasized. The commitment of the provincial government is needed. The responsibility should fall to the Minister of Hospitals and Medical Care and that responsibility should be legislated in the Mental Health Act.

The Minister should have the duty of ensuring the establishment and continuance of facilities designated for observation and assessment in smaller centres throughout the province (DF1's), of at least one regional psychiatric facility in each regional mental health area (DF2's), and of at least two provincial psychiatric facilities to serve the province as a whole (DF3's).

The Minister should use all of the means at his disposal actively to encourage hospital boards at the local and regional levels to undertake the functions of designation. Those means should include the provision of financial incentives and assistance to make physical renovations; to recruit, upgrade and train staff; and to do other things necessary to meet the standards for designation. We do not contemplate interference with the independent functioning of these boards apart from imposing stan-

dards which must be met and maintained for designation at each level (see 6.4 Specification of Standards for Facilities).

The relationship between the Minister and hospital boards will be very important. The Minister should assign a person to meet with hospital boards to explain what designation as a facility entails and to advise about the support the Minister is willing to give.

6.4 Specification of Standards For Facilities

The Task Force recommends that the government should investigate and develop an appropriate set of standards for the operation of each level of designated facility. The standards should be fixed in Regulations promulgated by the Lieutenant Governor in Council. The standards should specify the minimal resources that must be available for designation as a facility at each level.

We believe that involuntary patients are entitled to receive the best services and care available. The deprivation of liberty gives rise to this as a corresponding right. The more severe the condition, the greater should the application of resources to attend to it. We see a comparison with intensive care units for patients suffering from severe physical illnesses.

The selection of the standards themselves is a technical matter beyond our scope. The government may wish to develop its own standards, or ascertain them by reference to the standards set by an existing independent national "standards" body such as the Canadian Council on Hospital Accreditation. The standards should accord with what experts would recommend for given facilities or services. They should cover the following areas: qualifications of staff; number of staff to provide an adequate ratio of staff to patients; the attributes of an adequate physical setting; laboratory and equipment needs; and the basics of good clinical programming. They might include the provision of programs for outpatient clinical service and follow-up, contact with community residential accommodation, and a range of support service programs.

The minimum standards should include a guarantee of a certain level of care. That is not to say that there has been a marked departure from acceptable standards in this province but rather that we would like to see a statement of standards. They should cover such matters as: the use of physical restraints and isolation; loss of privileges; hygiene; nutrition; the right of the patient to wear his or her own clothes and to keep and use his or her own possessions including toilet articles; the provision of adequate physical space for each patient; access to individual storage for a patient's private use; provision for the safekeeping of personal possessions; and other matters relating to the patient's basic living accommodation and the enhancement of his personal dignity and self-esteem. (See also 15.2 and 15.3.)

The Minister of Hospitals and Medical Care should be responsible to establish a system of monitoring the practice to ensure that the standards are met.

VII. ADMISSION TO A FACILITY

7.1 General Comments

7.1.1 Overview

The Mental Health Act provides for admission to a facility on the authority of the certificates of two physicians, each of whom has examined the person separately and formed the opinion that he satisfies the criteria for compulsory hospitalization. The Task Force favours the continuation of medical admission, finding this preferable to admission following judicial proceedings. Patients and families subjected to the latter in the past have described it is humiliating.

Mental disorder is essentially a medical problem and the presence of the disease often impairs the judgment of the patient. We are confident that medical practitioners take their responsibilities under the Act very seriously and exercise their judgment carefully and in good faith. The guarantees of the Charter can be met by a review of the merits of the hospitalization afterwards (see chapters XIII and IV).

The Task Force recommends the introduction of three progressive stages of involuntary hospitalization. The progression would commence with the issue of a certificate of admission to a DF1. The purpose of involuntary detention at a DF1 would be assessment by way of observation and examination. In a proper case, it would be followed by the issue of a certificate of admission to a DF2 and the possibility of renewal of hospitalization at the DF2. That, in turn, would be followed by the issue of a certificate of admission to a DF3 and the possibility of the renewal of hospitalization at the DF3. The purpose of involuntary detention at a DF2 or DF3 would be hospitalization for treatment. The main difference between the provisions we recommend for detention at these two levels of facility is the length of authorized stay.

7.1.2 Basis For Opinion of Physician

The Mental Health Act requires certificates to be based on the opinion of the issuing physician, but does not specify the basis for the opinion. The form includes space for a statement of the facts upon which the physician bases his opinion. We think the legislation should require that the opinion of the physician be based on reasonable and probable grounds and that the grounds be set out in the certificate.

7.1.3 Duty to Issue Certificate Where Criteria Satisfied

It should not be open to a physician on the staff of a facility arbitrarily to refuse admission to a patient conveyed to the facility under certificate. We recommend that a legislative duty be placed on a physician on the staff of a DF1, DF2 or DF3 to

issue a certificate in respect of a person where the physician forms the opinion that the criteria for certification are satisfied.

7.2 Admission to a DF1

7.2.1 Issue of Admission Certificate (sections 14, 19(2))

Section 14 of the Mental Health Act authorizes a physician who examines a person to issue a conveyance and examination certificate. The certificate is based on the opinion of the examining physician that the person is

(a) suffering from mental disorder, and

(b) in a condition presenting a danger to himself or others.

The certificate must be issued not later than 72 hours after the examination.

Section 19(2) gives one admission certificate the same effect and authority as a conveyance and examination certificate. We understand the practice now to be for a physician in the community to issue an admission certificate rather than a conveyance and examination certificate. This practice eliminates the need for one of the two subsequent examinations which would otherwise be required to authorize admission to a facility.

Taking the change of practice into account the Task Force recommends the modification of section 14 to provide for the issue of a certificate of admission to a DF1 for the purpose of observation and assessment.

The language of section 14 is permissive. The physician may decide that the case is not serious enough to warrant initiation of the process leading to compulsory hospitalization. He may undertake a course of treatment with the consent of the patient, or direct him to appropriate resources in the community for help, as is advisable in the circumstances. We think it is appropriate to leave room for the exercise of discretion by the examining physician.

Section 14 is silent about the willingness of the patient to undergo treatment, or observation and assessment, voluntarily. In order to bring the DF1 certificate in line with the criteria for hospitalization in a DF2 or DF3 we recommend a third criterion be added. The physician must be of the opinion based on reasonable and probable grounds that the person is:

(a) suffering from mental disorder,

(b) in a condition presenting a danger to himself or others, and

(c) incompetent to give a valid consent to treatment or, if competent, refuses to be hospitalized as a voluntary patient.

The Task Force regards 72 hours after the examination as an unnecessarily long time for the issue of the certificate. We recommend 24 hours as an ample time for the physician to act. There should be no undue delay in a case grave enough to require certification.

7.2.2 Effect of Admission Certificate

Authority to Convey (section 15(1))

Section 15(1) provides that a conveyance and examination certificate is sufficient authority

(a) for any person to convey the person named in the certificate to a facility within 72 hours of the time it is issued and to detain that person while he is being so conveyed until the time he arrives at the facility, and

(b) for any physician to prescribe treatment for or to treat the person named in the certificate while he is being so conveyed and until the time he arrives at the facility.

We would apply the provisions of section 15(1) to a certificate of admission to a DF1 with the following modifications:

(1) The certificate should name the facility or identify the level of facility to which conveyance is authorized.

(2) The authority in paragraph (a) to detain the person during conveyance should be qualified so as to authorize the exertion of minimal restraint.

(3) The authority to treat at the DF1 level should be restricted to the minimum treatment that in the opinion of the physician is essential to care for, detain and control the person for the purpose of observation and assessment. We find the authority in paragraph (b) "to prescribe treatment for or to treat" during conveyance to be excessively broad in the circumstances.

Seventy-two hours should continue to be the allotted time for conveyance.

Authority to Observe and Examine (section 15(2))

Section 15(2) provides that, upon arrival at a facility, the conveyance and examination certificate is sufficient authority

(a) for one or more physicians who are members of the staff of the facility to observe and examine the person named in the certificate,

(b) to provide any treatment that in the opinion of the physician may be essential for the well-being of the person named in the certificate, and

(c) to care for, detain and control the person named in the certificate.

The authority lasts for 24 hours.

The Task Force would apply the provisions of section 15(2) to a certificate of admission to a DF1 with the following modifications:

(1) The provision of treatment in paragraph (b) should be restricted to the "minimum" treatment that in the opinion of the physician is essential to care for, detain and control the person named in the certificate for the purpose of observation and assessment. (With regard to the authority to treat under a certificate of admission to a DF2 and DF3, see chapter XV.)

(2) Where restraint is necessary under paragraph (c) the restraint employed should be the minimum necessary to care for, detain and control the person.

(3) The period authorized for observation and examination should be increased from 24 hours to not more than 96 hours. Information provided to us from many quarters suggests that 24 hours is insufficient time. The times in effect in other jurisdictions tend to range from 72 hours to 120 hours. The time extension will allow for a more thorough observation and a better basis for the forming of an opinion on the examination. Evidence from Ontario indicates that longer initial periods of hospitalization lead to more early discharges and changes to voluntary status (Stewart Page, "New Civil Commitment Legislation – The Relevance of Commitment 'Criteria'" (1980), 25 Can. J. Psychiatry, at 650). Although a person may be deprived of his liberty for a longer period under our proposal, it is to be remembered that he will be detained in a facility near at hand, and the dislocation and inconvenience caused to him will be lessened.

7.2.3 Obligation to Examine (section 17(1))

Section 17(1) renders obligatory the examination of a person detained on a conveyance and examination certificate. We would adopt the same provision for admission to a DF1, but would include reference to examination by a physician on the staff of the facility.

Section 17(1) also requires the examination to be conducted as soon as possible. This would defeat the objective of introducing an extended period of time for observation of the person and the recording of his activities and behaviours by nursing staff. The Task Force thinks that the obligation should be to conduct the examination at an appropriate time within 96 hours of the time the person arrives at the facility, given the circumstances.

7.2.4 Disposition After Examination (section 17(2))

Under section 17(2), the person must be released from the facility unless two admission certificates are issued within the 24-hour period provided for examination. We would amend this section to require release unless within the 96-hour period a member of the staff of the DF1 issues a certificate of admission to a DF2 or, on a rare occasion, depending on the physician's view of the severity of the individual's condition, to a DF3. (For the effect of the admission certificate, see 7.3.4. For the responsibility to arrange transportation to another facility or to return the person home, as the case may be, see 10.3.)

7.3 Admission to a DF2 or DF3

7.3.1 Issue of Admission Certificates (section 18(1))

Section 18(1) of the Mental Health Act directs the issue of admission certificates by two physicians, who, after separate examinations by each of them, are of the opinion that a person is

(a) suffering from mental disorder,

(b) in a condition presenting a danger to himself or others, and

(c) unsuitable for admission to a facility other than as a formal patient.

The Task Force recommends the adoption of this section for certificates of admission to a DF2 or a DF3 with the following modifications:

(1) The opinion should be based on reasonable and probable grounds (see 7.1.2).

(2) The third criterion should be reworded to say "incompetent to give a valid consent to treatment or, if competent, refuses to be hospitalized as a voluntary patient" (see 5.3.3).

(3) The certificate should be be issued not later than 24 hours after the examination.

7.3.2 One Certificate to be Issued by Psychiatrist on Staff of Facility (section 18(2))

Section 18(2) requires at least one of the admission certificates to be issued by a member of the staff of the facility to which the person examined is intended to be admitted. The provision applies where at least one of the examinations is not conducted at the facility.

We agree with the policy of this provision, and would apply it irrespective of where the examinations take place.

Given our premise that the DF2 and DF3 levels of facility will provide high quality psychiatric diagnosis, care and treatment, we recommend that the staff member should be a psychiatrist.

We recommend that the other certificate should be issued by a physician on the staff of the same or another facility within the province, be it a DF1, DF2 or DF3. A physician on the staff of a facility may be expected to have developed some specialized knowledge of mental disorder although not as much as a psychiatrist.

7.3.3 Effect of Two Admission Certificates (section 19(1))

Section 19(1) provides that two admission certificates are sufficient authority to "observe, examine, care for, treat, control and detain the person named in them, in a facility". The authority endures for a period of one month from the date of issue of the second certificate.

The Task Force agrees with the authority conferred, but recommends that the certificates should be required to be issued within seven days of each other. Seven days is the maximum time allowed under our recommendations for conveyance to a facility (up to 72 hours) and observation and assessment upon arrival (up to 96 hours).

The authorized period of detention should be stated in days for ease and accuracy of calculation. The initial period of detention at a regional psychiatric facility (DF2) should be 14 days. At a provincial psychiatric facility (DF3) it should be 30 days.

The time should be measured from the date of issue of the second certificate. (See chapter XV for our recommendations on the authority to treat.)

7.3.4 Effect of One Admission Certificate (section 19(2))

Section 19(2) provides that one admission certificate has the same effect and provides the same authority as a conveyance and examination certificate. It should be amended to provide that one certificate of admission to a DF2 or DF3 has the effect of a certificate of admission to a DF1 (see 7.2).

The certificate would confer the authority for any person to convey the patient to the DF2 or DF3 named in the certificate within 72 hours of its issue, and to exert minimal restraint to detain him during conveyance. It would further confer the authority for any physician to prescribe or provide the minimum treatment essential to care for, detain and control the person during conveyance. Upon arrival at the facility it would authorize observation and examination by one or more staff physicians, the prescription and provision of treatment essential to care for, detain and control the patient, and the exertion of minimal restraint in the care, detention and control of the patient for not more than 96 hours after arrival.

Examination by a psychiatrist on the staff of the facility within 96 hours of the patient's arrival would be obligatory.

Release upon the expiration of the 96-hour period would be mandatory unless a certificate of admission to a DF2 or DF3 is issued by a staff physician within that time.

7.4 Renewal of Certificates at a DF2 or DF3

7.4.1 Extension of Period of Detention (section 20(1))

Section 20(1) of the Mental Health Act permits a patient's detention to be extended by renewal certificates issued by two physicians who, after separate examinations by each of them, are of the opinion that the patient is

(a) suffering from mental disorder,

(b) in a condition presenting a danger to himself or others, and

(c) unsuitable for continuation at the facility other than as a formal patient.

We recommend the continuation of this provision making the following modifications:

(1) The opinion of each of the physicians should be based on reasonable and probable grounds (see 7.1.2).

(2) The third criterion should be reworded to say "incompetent to give a valid consent to treatment or, if competent, refuses to be hospitalized as a voluntary patient" (see 5.3.3.).

(3) The certificate should be issued within 24 hours of the examination.

7.4.2 One Certificate To Be Issued By Psychiatrist On Staff of Facility (section 20(2))

Section 20(2) requires at least one of the renewal certificates to be issued by a member of the staff of the facility where the examination was made.

We agree with the policy. We recommend that the one certificate should be issued by a member of the staff of the facility in which the patient is detained, and that the staff member should be a psychiatrist (see 7.3.2). The other certificate may be issued by any physician.

7.4.3 Effect of Two Renewal Certificates (section 20(3))

Section 20(3) provides that two renewal certificates are sufficient authority to "observe, examine, care for, treat, control and detain the person named in them. The first renewal certificates issued extend the period of detention up to two addi-

tional months. Each subsequent renewal adds up to six additional months.

We agree with the authority conferred, but recommend changes in the time periods.

Compulsory hospitalization at a regional psychiatric hospital is intended to accommodate intermediate lengths of stay. To avoid congestion at this level of facility, we recommend that the period of detention in a DF2 should be renewed on one occasion only. The period of renewal should not be more than 14 days. As as a result, no person should be detained as an involuntary patient at a DF2 for more than 28 consecutive days. Where further hospitalization is required on a compulsory basis a physician on the staff of the DF2 should issue a certificate of admission to a DF3 before the expiration of the renewal period.

We would stipulate the periods of renewal at a provincial psychiatric facility (DF3) in days rather than months (see 7.3.3). The first renewal should not be for more than 60 additional days. Any subsequent renewal should not be for more than 180 additional days.

(See chapter XV for an extended discussion of the authority to treat.)

7.5 Expiration of Certificates at a DF2 or DF3 (section 20(4))

Section 20(4) provides that an involuntary patient whose certificates have expired is a voluntary patient not subject to detention and that he shall be informed of that fact. It should be retained.

7.6 Cancellation of Certificates (section 20(5))

Section 20(5) provides that when an involuntary patient agrees to become a voluntary patient his hospitalization may be continued in accordance with the by-laws of the hospital board and the certificates shall be deemed to be cancelled. The provision should be retained.

7.7 Waiving Where No Psychiatrist On Staff

The Task Force has recommended that at least one of the certificates of admission to, or renewal of detention at, a DF2 or a DF3 must be issued by a psychiatrist on the staff of the facility. By psychiatrist, we intend a physician who is recognized by the College of Physicians and Surgeons of Alberta as a specialist in psychiatry. A facility may not have a psychiatrist who meets these qualifications on its staff. We therefore recommend that if by reason of emergency the facility is temporarily without a psychiatrist on its staff, the requirement that one of the certificates be issued by a psychiatrist may be waived.

VIII. CONTENTS OF CERTIFICATES

8.1 Contents (sections 16, 18(3), 21)

Sections 16, 18(3), and 21 of the Mental Health Act specify the contents of a conveyance and examination certificate, an admission certificate and a renewal certificate, respectively. Each certificate must show

(a) the name of the physician issuing it,

(b) the date and time the personal examination was conducted,

(c) the facts on which the physician formed his opinion that the person

  (i) was suffering from mental disorder, and

  (ii) was in a condition presenting a danger to himself or others.

  distinguishing the facts observed by him from the facts communicated to him by others, and

(d) the date and time of issue.

Under section 10(a) of the Charter the patient has the right to be informed promptly of the reasons for his detention. The European Human Rights Commission in the case of *X* v. *United Kingdom* held that the reasons must provide the patient with a sufficiently detailed explanation to enable him to know the allegations and decide whether he has a case for review. The point is discussed more fully in Chapter XII. Notification of Rights.

In the view of the Task Force, the certificates authorizing the detention should contain this information. That is to say, each certificate should, on its face, make out the case for detention by giving the facts which would persuade an objective reviewer (e.g. a review panel) that the issue of the certificate was warranted. It should contain the facts to demonstrate mental disorder and dangerousness. Check marks opposite the headings "facts observed by me" and "facts communicated by others" are not adequate. Nor should a certificate omitting the date and time of its issue be valid. Information before us suggests that certificates do not always give complete information.

The certificate should set out:

(1) the name and address of the physician issuing it. The form now provides for the inclusion of the address, but the requirement is not legislated. We think that it should be.

(2) whether the physician issuing it is a member of the staff of a facility and, if so, the name of the facility. This is new.

(3) the date and time the personal examination was conducted. This is now required.

(4) the reasonable and probable grounds on which the physician formed his opinion that the person was

  a) suffering from mental disorder,

  b) in a condition presenting a danger to himself or others, and

c) (where the certificate authorizes detention in a DF2 or DF3) incompetent to give a valid consent to treatment or, if competent, refused to be hospitalized as a voluntary patient.

The opinion set forth in the certificate should be based on due and adequate inquiry. It should distinguish the facts communicated to the examining physician by the patient from those communicated to him by others. Attempts made to contact members of the person's family or other persons with knowledge of his recent behaviours should be shown. It should also indicate whether the physician had access to and did review the person's past medical history or clinical records.

In setting out the facts, the physician should use behavioural descriptions rather than diagnostic categories. He should clearly state in narrative, not summary or abbreviated form, the basis for his opinion with respect to satisfaction of each of the criteria.

(5) the facility to which the person identified is intended to be admitted. This, again, is new.

(6) the date and time of issue followed by the signature of the issuing physician.

8.2 Validity

Section 44 saves the validity of certificates and other documents issued under the Mental Health Act or its Regulations. The section provides that a document "shall not be held to be insufficient or invalid by reason only of any irregularity, informality or insufficiency in it or in any proceedings in connection with it". This may explain why certificates are not completed with as much care and attention as one might desire.

The saving under section 44 is far too wide given that the issue of certificates deprives a person of his liberty. To be valid, a certificate must be complete. The test of the sufficiency of the grounds given as the basis for the opinion of the issuing physician should be that the certificate discloses on its face the reasonable and probable grounds which to an objective observer would warrant detention under the Act. If this test is not met or the certificate is otherwise incomplete, it should be invalid.

The Task Force considered the possibility of imposing a penalty for an incomplete certificate. We are content, however, to let the existing possibility of civil liability for wrongful detention by the physician purporting to issue the certificate and the facility detaining the person serve as a deterrent.

IX. APPREHENSION FOR EXAMINATION

9.1 Introduction

Where a person manifests signs of mental disorder, the first objective should be to bring him to a physician for a medical opinion as to his condition and the administration of treatment if required. Preferably, the physician should be the person's family or personal doctor, and failing this a physician in the immediate community.

If the person is unwilling or refuses to see a physician, the Mental Health Act provides two methods to compel him to undergo a medical examination. The first (section 22) is the issue of a judicial warrant which authorizes a peace officer to apprehend the person and convey him to a facility (usually Alberta Hospital, Edmonton; Alberta Hospital, Ponoka; or one of the three Calgary general hospitals designated for the limited purpose of compulsory examination). The second (section 23) is apprehension by a peace officer on his own power which is intended to be exercised in an emergency when circumstances militate against taking time to lay an information for the issue of a warrant by a provincial judge. Again the power is to convey the person to one of the aforementioned facilities, which could be a considerable distance from home.

The adoption of our proposal for the establishment of facilities for observation and assessment in smaller centres would ameliorate the problem of distance to a considerable extent. However, in order to further the objective of examination by the family physician or a physician in the community further steps are necessary.

In this chapter, the Task Force makes recommendations for the improvement of sections 22 and 23. It also recommends the introduction of an additional authority for getting a person to a physician for examination: "the issue of a directive by an approved mental health professional".

9.2 Proposal For the Issue of a Directive By An Approved Mental Health Professional

9.2.1 Summary of Proposal

Our proposal would authorize an approved mental health professional to issue a directive requiring a person to be examined by a physician. The directive would have no legal effect. The fact that legislation authorizes the directive to be issued would, however, give it a persuasive effect which we think would be helpful in some circumstances. Failure to comply with the directive would lead to the bringing of an information for the issue of a judicial warrant compelling apprehension and examination. This knowledge would add to the authority of the directive.

9.2.2 Reasons for Proposal

Members of professions other than medicine play a valuable role in the delivery of mental health services and care in the community. Psychologists, psychiatric nurses, public health nurses, social workers, or marital and family therapists may

come into contact with aberrant behavior before a physician does. The training and experience of such professionals may equip them to recognize when the symptoms of mental disorder are severe enough to call for a medical examination and, possibly, hospitalization.

Initially, a mental health professional in this position would be expected to use all means of encouragement, all the wiles and skills at his disposal, to persuade the person to undergo a voluntary examination. Even better is the possibility of arranging for the physician to go to the person.

In the recommendations which follow, we propose that where friendly coercion fails to elicit voluntary attendance and the mental health professional is of the opinion that there are grounds for compulsory hospitalization, he should be authorized to issue a formal directive requiring the person to attend for an examination by a physician.

Keeping the matter in the therapeutic setting would be advantageous. The allegedly sick person would not have to be picked up or forcibly conveyed by law enforcement officers in a manner more akin to the criminal process. There is less stigma attached to seeing a physician in the company of a mental health worker than to being transported to a facility in a police car.

9.2.3 Meaning of "Approved Mental Health Professional"

The Task Force would place responsibility with the governing professional bodies of various disciplines to develop criteria, in terms both of academic qualification and clinical experience with mental disorder, for the registration of members authorized to issue directives under the Mental Health Act. The Task Force has in mind the Alberta Association of Registered Social Workers, The Psychologists Association of Alberta, The Alberta Association of Registered Nurses, The Association of Registered Psychiatric Nurses and The Association of Family and Marital Therapists.

The professional associations should be responsible for the establishment of criteria, assessment of members wishing registration, and registration with the designated professional associations, subject to the approval of the Minister.

9.2.4 Basis For Issue of Directive

We recommend that a directive may be issued by an approved mental health professional where he is of the opinion based on reasonable and probable grounds, including personal observation, that a person is

(a) suffering from mental disorder,

(b) in a condition presenting a danger to himself or others, and

(c) unwilling to be examined by a physician.

The Task Force believes that where these conditions exist the mental health professional should act promptly. Ideally the directive would be issued and served forthwith.

9.2.5 Contents

The directive should be written in simple language. It should require the patient to present himself, in the company of the mental health professional, for examination by a physician within 24 hours of personal service. The physician may be one of the person's choice, perhaps a physician practising in the local community or with the regional mental health clinic. Failing the patient's choice, the examination should be conducted by a physician on the staff of the DF1 specified in the directive.

The directive would state:

(1) the name, address and profession of the person issuing it;

(2) the facts which caused the mental health professional to believe that the person is

  (a) suffering from mental disorder,

  (b) in a condition presenting a danger to himself or others, and

  (c) unwilling to be examined by a physician, distinguishing the facts observed by him from the facts communicated to him by others;

(3) the date and time when the belief was formed;

(4) the date and time of issue; and

(5) the date and time of service.

The directive should include a statement to the effect that the registered mental health professional who issues it is willing to set up an appointment with a physician of the patient's choice, provide him with transportation, accompany him to the physician, and give such other assistance as he can to help the patient satisfy the requirements of the directive.

The directive should also state that in the event of failure by the person to comply with it, the mental health professional would bring an information under oath before a provincial judge for the issue of a judicial warrant for apprehension. The failure to comply would be one of the grounds given in support of the issue of a warrant (see 9.2.7).

9.2.6 Service

The directive should be served personally by the mental health professional issuing it. At the time of service the mental health professional should give the person a simple oral explanation of its contents. Ideally, the mental health professional would

hand the written directive to the person, discuss it with him, and offer both his assistance and his company.

If there is a language difficulty an interpreter should be provided. The right to the assistance of an interpreter is discussed in chapter XI.

9.2.7 Effect

The directive should constitute the authority for a physician to examine the person named in the directive when, within 24 hours of its service, he attends for examination in the company of the mental health professional who issued the directive.

9.2.8 Failure of Person to Comply

The failure of the person named in the directive to comply would lead to proceedings being taken by the mental health professional to obtain a judicial warrant for apprehension, a consequence of which would be compulsory examination. The directive, as we have said, should explain this.

9.3 Judicial Warrant For Apprehension (section 22)

9.3.1 Bringing of Information (section 22(1))

By Any Person

Section 22(1) permits an information under oath to be brought before a provincial judge by anyone having reasonable and probable grounds to believe that a person

(a) may be suffering from mental disorder, and

(b) is in a condition presenting a danger to himself or others.

The section enables a concerned relative, friend or neighbour to initiate the process for compulsory examination.

We recommend that section 22(1) be continued.

By An Approved Mental Health Professional

Our recommendation to permit an approved mental health professional to issue a directive will give a concerned intervener the option of asking a mental health professional to use his authority to deal with the problem. We think that many people would find this option less stressful than bringing an information. It permits a more therapeutic attempt at dealing with the problem and avoids the heavy-handedness of judicial process and law enforcement officers.

If the issue of the directive does not achieve the desired result, the approved mental health professional should bring an information. The information should spell out the steps taken by the mental health professional to secure compliance with the

directive and the circumstances of the failure to comply. A copy of the directive should be attached to the information.

9.3.2 Basis For Decision of Judge (section 22(2))

Section 22(2) empowers the judge to issue a warrant for apprehension where he is satisfied that

(a) the person with respect to whom the information is brought should be examined in the interests of his own safety or the safety of others, and

(b) an examination can be arranged in no other way.

This section is silent about the process by which the judge is to satisfy himself.

A warrant authorizes the person named to be picked up and conveyed (this may take up to 72 hours) to a DF1 for observation and assessment (under our recommendations, the permissible period is up to 96 hours). Treatment, albeit minimal, may be imposed against the person's will for the entire time.

Hopefully, the conveyance will not take 72 hours because the facility will be in the immediate vicinity. The 96-hour period need not be utilized in full where it is apparent sooner that certification is not justified. It is unlikely, therefore, that the person will be deprived of his liberty for a full 7 days before the error in judgment is detected and set right. Nevertheless, the total procedure may turn out to have been invoked without justification when the wisdom of hindsight takes hold. We believe that the possibility for error should be minimized.

There is potential for abuse. Well-meaning but untrained persons, especially loved ones who are emotionally affected by the behaviours, may be overzealous in their efforts to protect their family member, friend or acquaintance or seek their own personal peace of mind. Concern for the welfare of an allegedly sick person and for the protection of others may motivate a judge who has only the sworn information before him to issue the warrant rather than refuse it.

The intemperate viewpoint, poor judgment, or whim of an informant should not go unchecked. The Task Force debated how the process could be more deliberative. We realize that fast medical attention will be needed in the majority of cases. Time will be at a premium and it will be important to act quickly, although without the urgency contemplated for apprehension by a peace officer acting on his own authority under section 23.

We considered three possibilities: (1) issuing a summons for the person who is the subject of the information to appear; (2) introducing a form of notice to him; and (3) requiring the person

swearing the information to appear before the provincial court judge for questioning.

We were dissuaded, by the risk of delay, from requiring the subject of the information to appear. We would not want to interpose cumbersome judicial proceedings while a sick person awaits much-needed medical attention. This step would be retrogressive, reintroducing the problems which existed before 1964 when appearance in court routinely preceded hospitalization. Experience has shown that legal formalities exacerbate the stress, agony, confusion and humiliation already being experienced by the persons concerned.

We were dissuaded from introducing a form of notice to the subject of the information because the person is apt to have been apprehended before he receives the formal notice.

We recommend that the person bringing the information should be required to appear before the judge for questioning on the information. This is the practice currently being followed by family court judges in Calgary and Edmonton. The proceeding should be on the record: a clerk should be present to transcribe it or it should be recorded in accordance with the Mechanical Recording of the Evidence Act, R.S.A. 1980, c.M-11. The warrant should be based on current information. Where possible, the person's past medical history should also be made known to the judge. The judge should be informed of previous warrants, if any, and their outcome. These safeguards should help curb the possibility of warrants being issued on ill-founded grounds.

9.3.3 Powers of Judge (section 22(2))

Where the judge is satisfied that the conditions exist, section 22(2) authorizes him to issue a warrant to apprehend the person for an examination. The provision should be continued.

We recommend that the judge should also be empowered to order a physician to visit and examine the person who is the subject of the warrant. In this circumstance, a warrant should not be issued unless the physician is unable to conduct the examination. (Compare R.S.N.S. 1967, c. 249, s. 29(2).)

9.3.4 Effect of Warrant (section 22(3) and (4))

Section 22(3) provides that a warrant may be directed to all or any peace officers and that it shall name or otherwise describe the person with respect to whom it is issued.

In our view, the warrant should contain more than the name or description of the person who is the subject of the warrant. We recommend that the peace officer acting on the warrant should be informed of the background of the person named in the warrant and of the events leading to its issue.

We would prefer that, where possible, the apprehension should be made by a police officer wearing plain clothes and driving an unmarked vehicle. This, however, is not a matter for legislation.

Section 22(4) provides that upon apprehension the warrant has the effect of a conveyance and examination certificate.

We accept the policy of this provision, but it should be reworded to give the warrant the effect of a certificate of admission to a DF1.

9.3.5 Duration of Warrant

A warrant should not remain outstanding indefinitely as seems to be possible now. The Task Force recommends seven days as an adequate life for a warrant, given the seriousness of the circumstances and the importance of acting promptly.

9.3.6 Disposition of Warrant

There should be a procedure for return of the warrant to the provincial judge who issued it together with a statement as to its disposition. That is to say, the judge should be informed whether or not the warrant has been executed and, if not, he should be given an explanation of the action taken and the reasons for the failure to execute it. A statement of the disposition should also go to the person who brought the information so that further action may be taken by him if necessary.

9.4 Peace Officer's Power (section 23)

9.4.1 Basis of Exercise (section 23(1))

Section 23(1) provides that when a peace officer observes a person

(a) apparently suffering from mental disorder,

(b) in a condition presenting a danger to himself or others, and

(c) acting in a manner that in a normal person would be disorderly,

he may convey the person to a facility for an examination if he is satisfied that

(d) the person should be examined in the interests of his own safety or the safety of others, and

(e) the circumstances are such that to proceed under section 22 would be dangerous.

The requirement of personal observation imposes practical limitations. The person may be on private premises where the peace officer cannot see him. He may be quiet when the peace

officer arrives but have been exceedingly disruptive or violent shortly beforehand.

We think that the peace officer should be able to intervene on information received from an eyewitness (e.g. the wife) when he believes that the situation is one of emergency. The requirement that the peace officer must observe the behaviour which signals the need for medical examination suggests that the power is intended to be used in cases of public disruption. Our recommendation tends to de-emphasize the public nature of the behaviour and place the emphasis on the degree of emergency in the situation. The immediacy of the risk of danger occurring is our first concern.

We recommend that the opening words of section 23(1) be rewritten to allow a peace officer to intervene on the basis of reasonable and probable grounds for belief. The word "apparently" at the beginning of paragraph (a) should be deleted because we would replace the necessity for observation with reasonable and probable grounds for belief.

Paragraph (c) is an irrelevant consideration and should be deleted. Subject to 9.4.2, we would retain the remainder of the section.

Here again, our recommendation to empower an approved mental health professional to issue a directive gives the concerned or threatened relative, friend, neighbour or other person an option. He may choose to call upon a mental health professional who would then call in a peace officer because of the urgency of the situation. The opinion of the mental health professional that the situation requires immediate intervention would assist the peace officer in coming to his own conclusion under section 23(1) that paragraphs (d) and (e) are satisfied.

We believe that these amendments will help peace officers to act in emergency situations.

9.4.2 Extent of Power (section 23(1))

Section 23(1) empowers the peace officer to convey the person to a facility for examination. The facility should be a DF1.

9.4.3 Effect of Exercise (section 23(2))

Section 23(2) provides that a person conveyed to a facility under the peace officer's power should be deemed to be a person in respect of whom a conveyance and examination certificate has been issued.

The section should be reworded to refer to a certificate of admission to a DF1.

X. MATTERS RELATING TO CONVEYANCE AND ADMISSION

10.1 Reception of Person By Facility

The Task Force thinks that reception for observation and assessment at a DF1 should be mandatory where the person is presented pursuant to the authority of a certificate issued by any physician, a judicial warrant, or a peace officer's apprehension.

If the facility, for some special reason, is not equipped to contain the patient an examination may be conducted expeditiously by a DF1 physician. If the criteria are satisfied the physician can issue a certificate authorizing conveyance for observation and assessment at a DF2 within the region. It may be necessary to take this step where the patient is grossly disturbed and his need to be detained in a better-staffed, more secure facility becomes quickly apparent. Ideally, as soon as the certificate is issued the DF2 would be contacted and administrative arrangements made to facilitate a smooth transfer of the patient from the DF1 to the DF2.

It should be mandatory for a DF2 to receive for observation and assessment, but not necessarily to admit, a patient certified for admission by a DF1 physician. It should likewise be obligatory for a DF3 to receive for observation and assessment a patient certified for admission by a DF1 or DF2 physician. Admission would ensue where a psychiatrist on the staff of the DF2 or DF3 issues a certificate following examination of the patient within 96 hours of his reception for observation and assessment. Administrative arrangements should be made ahead of time for the reception of the patient at the facility to which he is being transferred.

The responsibility of the peace officer or other person escorting a person to a facility should end when he turns the person over to the staff of the facility to undergo the check-in procedure. The escort's time should not be tied up waiting for a medical examination to be performed. If he is able to provide relevant background information it should be obtained before he leaves the facility, but this is not a legislative matter.

10.2 Refusal to Hospitalize

Section 12 of the Mental Health Act requires the board of a facility to inform a person refused admission of the reasons for the refusal and permits it to refer the person to another facility or service. It obliges the board, if possible, to inform the referring source of the reasons for refusal. Where alternative arrangements are made the section requires the referring source to be informed of them.

Under our recommendations, the board of a facility is obliged to receive, for observation and examination, a person presented pursuant to a certificate of admission, judicial warrant or peace officer's power. The period of up to 96 hours reserved for this purpose is intended to give a physician on the staff of a facility a better basis upon which to make his examination and form his opinion. The full 96 hours need not be utilized

in every case. To the contrary, the facility physician may form his opinion upon examination at any time after the person is presented to the facility for detention.

We recommend that a facility physician who forms the opinion that compulsory hospitalization is not justified should be required to state his reasons for refusing admission in a written certificate. The certificate should be similar in content to a certificate granting admission except that it should show the justification for the physician's opinion that the person does not meet the criteria for admission rather than the grounds to demonstrate that he does. Where the person is referred to another facility or service, the certificate should include a statement of any alternative arrangements. The process of completing the certificate should help to ensure that the decision to refuse is a considered one.

The certificate of refusal should be given to the person who is subject to the examination, any person he names to represent him, the nearest relative and the referring source, if any.

10.3 Conveyance to and from a Facility

10.3.1 Responsibility to Convey

Where a person is apprehended by a peace officer pursuant to a judicial warrant or the exercise of the peace officer's power, the officer is responsible to convey the person to a facility (under our recommendations, a DF1) for examination. The Mental Health Act does not assign the responsibility for conveyance to a facility pursuant to the authority of a certificate issued by a physician in the community, or for the transfer of an involuntary patient from one facility to another, or for his return transportation when admission is refused or he is discharged.

Police legitimately object to travelling many miles from their home jurisdictions, taking several hours of their time before an examination is conducted, only to find that admission is refused and that their responsibility for the person continues to be a problem.

Our recommendations for legislation will alleviate some of the difficulties. Our recommendation for local observation and assessment facilities (6.2) will minimize the problem of distance. Our recommendation for the immediate reception of the person by the facility (10.1) will minimize the problem of waiting time. Our recommendation for the arrangement of transportation home by the facility (10.3.2) will shift the problem of disposition where admission is refused.

The Task Force is not convinced that conveyance by a peace officer is the best solution in every case. Sometimes it may be preferable to transport the person by private vehicle. At other times a ground or air ambulance may be required.

We do not believe that the responsibility for conveyance should be assigned in legislation. We would, however, urge the government to designate the persons or agencies responsible as a matter of policy.

10.3.2 Arrangements for Conveyance

Regional mental health clinics may be able to play a role in making arrangements for the initial conveyance to a DF1 pursuant to a physician's certificate, judicial warrant or the exercise by a peace officer of his power. Thereafter the board of the detaining facility should be responsible for transportation arrangements. Where the person is refused admission the board should have the duty to arrange for his transportation back to his place of residence or other appropriate place. When a certificate of admission to another facility is issued, the board should be responsible to arrange for his transportation to that facility. If the patient is admitted to the detaining facility and later discharged (see chapter XX) the board should be responsible to make arrangements for his return home. Where the patient is to be transferred to another facility at the same level (see 18.1) or to a hospital for treatment that cannot be supplied in the facility (see 18.2), again the board making the transfer should be responsible to arrange the transportation.

10.3.3 Cost

The cost of conveyance of a person under the compulsion of the Mental Health Act and his transportation home should be borne at public expense whether or not the detention results in hospitalization. A person should not be out of pocket when he has been brought to a facility against his will.

10.4 Transfer of Medical Record

We recommend that on any conveyance to or transfer between facilities the information essential to maintain the continuity of medical care must accompany the patient. That is to say, the record of an involuntary patient, whether in the form of the original or a copy, should follow him through continued detention for continuity of treatment. The board of the facility from which he is being moved should have a duty to forward his medical record without delay. On discharge, for follow-up purposes, disposal of the record to a department or agency of the government or a physician responsible for providing continued treatment to the patient may be appropriate on the discretionary basis authorized by section 37(6)(c) (see 17.6.3).

XI. RIGHTS OF PATIENT

11.1 Introduction

As a general principle, an involuntary patient should be free to exercise the civil rights which all citizens ordinarily enjoy. Indeed, section 15 of the Charter guarantees equality to persons suffering from mental disabilities (see 4.4).

Compulsory hospitalization restricts the exercise of many of these rights. The restrictions should not, however, be any greater than is required to achieve the societal goals of the detention. Legislation is required to ensure the fairness of the detention and to safeguard the civil rights which the detention should not curtail.

A number of major rights are discussed in separate chapters of this report – rights relating to:

- review of detention, (both by a review panel (Chapter XIII) and by the court (Chapter XIV));
- treatment (Chapter XV);
- patient advocacy (Chapter XVI);
- confidentiality of and access to the patient's medical records (Chapter XVII);
- transfer of a patient (Chapter XVIII);
- absence from hospital (Chapter XIX); and
- discharge (Chapter XX).

Other rights correspond to duties imposed on the board of the facility and are discussed in other contexts – for example, in connection with admission and detention, the rights to be:

- received for observation and assessment (see 10.1);
- informed of the reasons for the refusal to admit (see 10.2); and
- informed of the expiration of certificates (see 7.5).

In this chapter, the Task Force discusses a number of remaining rights which relate directly to the confinement – the rights:

- to be informed of reasons for detention and the avenue of review (section 24(1));
- to name a representative;
- to the assistance of an interpreter (section 24(2));
- to an independent medical opinion;
- to security (section 13(2));
- to be free from abuse;
- to unobstructed communication (section 30); and
- to receive visitors (section 31).

We also look at the rights of voluntary patients, and at the channels for complaint about the infringement of rights.

Insofar as they are appropriate and unless otherwise indicated, the rights safeguarded by the Act should apply to detention from the time of apprehension through to discharge. This would include the period during conveyance and the time spent at all levels of facility (DF1, DF2 and DF3).

11.2 Right To Be Informed of the Reasons For Detention and of the Right to Review (section 24(1))

Section 10(a) of the Charter guarantees to everyone "the right on detention to be informed promptly of the reasons therefor".

Section 10(a) is comparable to Article 5(2) of the European Convention on Human Rights which provides:

> Everyone who is arrested shall be informed promptly, in a language which he understands, of the reasons for his arrest and of any charges against him.

This provision was the subject of interpretation in the case of *X* v. *United Kingdom*. The pre-Court Commission hearing the case took a very dim view of the failure of the authorities to provide X and his legal advisors with an adequate explanation of the reasons for the revocation of X's probation. The Commission (in its Report at para. 111) submitted "there could have been no justification for withholding detailed information from persons acting on the applicant's behalf, namely his solicitors". The explanation that the applicant's case had given the authorities cause for concern was insufficient to enable effective and intelligent use of the right to bring proceedings for determination of the lawfulness of the detention.

Section 24(1) of the Mental Health Act reinforces the Charter guarantee. It requires the patient and his nearest relative to be given an oral explanation, in simple language, of the reasons for the issue of admission or renewal certificates. It further requires them to be given a written statement of

(i) the authority for his detention and the period thereof,

(ii) the function of the review panels,

(iii) the name and address of the chairman of the appropriate review panel, and

(iv) his right to apply to the review panel for cancellation of the admission certificates or renewal certificates.

The Task Force recommends that both an oral explanation and a written statement of the reasons for the hospitalization should be given. The patient should be entitled to be informed orally when he becomes capable of comprehending if he is not capable at the time of hospitalization. The reasons must be sufficient to allow him to assess the propriety of the detention. The written statement should include copies of the certificates of admission or renewal authorizing the detention.

The patient should also be given both both an oral explanation and a written statement of the right to review. Again, the oral explanation should be given at a time when the patient is capable of comprehending it and if he is not capable when hospitalized, as soon as he becomes capable.

As currently worded, section 24(1) does not specify who has the obligation to inform. The obligation should be placed on the board of the facility.

Under section 24(1), the patient's nearest relative is entitled to receive the same oral explanation and written statement as the patient. We recommend that a person named by the patient as his representative (see 11.3) should also receive an oral explanation and written statement.

We decided that the patient should not have the right to refuse notification to his nearest relative. Notification to the nearest relative, as defined in the Act, should be mandatory in all cases. It is imperative that someone outside the hospital be informed of the detention whether the patient names a representative or not.

11.3 Right to Name a Representative

The patient should have the right to name as his representative any person he perceives as being concerned for his well-being and likely to represent his interests. The representative should be entitled to receive all the notifications which go to the nearest relative, and to perform any other functions which are assigned to him by the Act. The patient should be free to consult his representative on any and all matters affecting him. Our recommendations for open communication should make this possible.

11.4 Right to the Assistance of an Interpreter (section 24(2))

Section 14 of the Charter declares that:

> A party or witness in any proceedings who does not understand or speak the language in which the proceedings are conducted or who is deaf has the right to the assistance of an interpreter.

The right guaranteed by section 14 of the Charter is satisfied in part by section 24(2) of the Mental Health Act. Section 24(2) obliges the hospital board to satisfy the requirements of section 24(1) through an interpreter in the event of language difficulty. The language is broad enough to include a person who is deaf.

To satisfy the Charter in full, the Mental Health Act should extend the right to an interpreter to proceedings taken before the review panel. We also recommend that the duty imposed on the Minister, in section 10, to render assistance to the review panel should include the provision of an interpreter where required.

Given the nature of psychiatric disorders and the intricate connection between communication, explanation for behaviour and diagnosis in psychiatric settings, a strong case can be made for accommodating the language or communication needs of patients as a component of care and treatment.

The Task Force declines to make legislative recommendations for the mandatory provision of interpreters in the therapeutic setting. We believe that insofar as it is practicable to do so, and in accordance with the dictates of sound medical practice, steps would and should be taken to overcome any language difficulties being experienced by a patient.

11.5 Right to an Independent Medical Opinion

A patient with doubts about his need for hospitalization or reservations about the treatment he is receiving would benefit from the opportunity to obtain an independent medical opinion.

We recommend that an involuntary patient should be entitled to one independent medical opinion from a physician of his choice funded by Alberta Health Care in accordance with its authorized fee scale. The right should recur with respect to every pair of certificates issued.

An involuntary patient should be entitled to any number of medical opinions based upon examination by physicians of his choice at his own expense.

Where the patient expresses the desire for an independent medical opinion, the facility should be under a duty to cooperate with the physician named so as to enable him to conduct his examination.

11.6 Right to Security (section 13(2))

Section 13(2) of the Mental Health Act obliges the board of a facility to determine what level of security is reasonably required for each patient in view of all the circumstances and thereafter to provide it and to review the necessary level of security at intervals of not more than 6 months.

The Task Force agrees that the board of the facility should be required to provide the level of security reasonably required for each patient for the purpose of protecting both the patient and others. The level of security, however, should be determined on an on-going basis and provided, as is needed, at any given point in time.

11.7 Right to Be Free From Abuse

We believe that a person detained under the authority of the Mental Health Act should be free from abuse. We recommend that the right to be free from abuse should be legislated. The right should cover the whole period of detention: apprehension, conveyance and hospitalization.

The Ombudsman has noted that there can be major disagreements as to whether a given form of conduct is acceptable or not (*Special Report of the Ombudsman — Ministerial Order Re: Alberta Hospital Edmonton,* July 1982, at 52). The absence of any clear statement of what constitutes patient abuse impeded his investigation of alleged incidents of abuse. He proposed that patient abuse should be defined as:

> ...any activity which physically, mentally or emotionally causes injury, damage, undue discomfort, elicits fear or takes unfair advantage of a client and is not part of a specific written treatment plan or approach. This includes verbal and physical assault.

The Task Force recommends that a definition of abuse should be developed by government officials and adopted in Regulations under the Mental Health Act. In determining what the definition should be, government officials should consider the Ombudsman's proposal and other suggestions.

We feel strongly that every precaution should be taken to prevent the occurrence of patient abuse. Hospital management should establish policies regarding acceptable standards of patient care. Staff should be educated about what constitutes abuse through the presentation of documented examples and detailed discussion of them. Procedures for reporting abuse should be developed which would facilitate immediate investigation. We recommend that the board of a facility should have a duty to draw up policies and undertake administrative measures to prevent the occurrence of abuse. The duty should be imposed by legislation.

Where patient abuse does occur, we recommend that it should be cause for dismissal and that the right to impose the sanction of dismissal should be legislated.

11.8 Right to Unobstructed Communication (section 30)

Section 30 give patients a completely unrestricted right of written communication. The Task Force recommends that the right should be expanded to include the right of a patient to have access to a telephone and the right to make and receive unmonitored telephone calls or to have such calls made for him, at his own expense, at all reasonable times. The right should not be restricted because a psychiatrist thinks phone calls would be detrimental either to the patient or to others.

11.9 Right to Receive Visitors (section 31)

Section 31(1) provides that a patient shall not be prevented from receiving visitors at hours fixed by the board unless a physician considers that a visitor would be detrimental to the patient's health.

We recommend that the section be reworded to permit a patient to see visitors each day at all reasonable times and in all reasonable circumstances unless a physician considers that visiting with a given individual would be detrimental to the patient's health.

Section 31(2) excepts a solicitor acting for the patient from section 31(1). He may visit the patient at any time. The exception should be continued and extended to include a person named by the patient as his representative (see 11.3), and members of the patient advocacy service which the Task Force recommends be created (see chapter XVI).

11.10 Rights of Voluntary Patients

A voluntary patient with a psychiatric disorder should have the same rights as a voluntary patient with any other disorder requiring hospitalization. He is not in a unique or special position. If he is dissatisfied with the medical attention he is receiving or with the conduct of hospital staff, he has the alternative of leaving. He therefore does not need the same legislative protection as an involuntary patient.

A few rights, nevertheless, need to be specifically guaranteed to a voluntary patient in a mental health facility. First and foremost, a voluntary

patient should have the right to be informed of his status at any and all times. He should know that he is free to walk out.

Second, a voluntary patient should be entitled to the protection of the confidentiality of and access to his medical records. The protections given to psychiatric patients in section 37 of the Mental Health Act are almost the same as those given to all patients in section 40 of the Hospitals Act. They do not give a psychiatric patient significantly greater rights. (See Chapter XVII. Patient Records).

Third, a voluntary patient should be entitled to notification of the rights associated with his status. (See Chapter XII. Notification of Rights).

Finally, a voluntary patient who is in doubt as to his status or rights should be entitled to the assistance of the patient advocacy service in seeking clarification.

11.11 Channels of Complaint

Several channels of complaint about improper care or treatment are available to a patient. The most controversial of these is the right to complain to the Provincial Ombudsman. Other channels include internal hospital review or appeal procedures, the Alberta Health Facilities Review Committee, and professional records or ethics committees and disciplinary bodies.

11.11.1 Ombudsman

The jurisdiction of the Ombudsman extends to government departments and agencies but not to boards of management of Provincial General Hospitals whose members, like those of the Mental Health Hospital Boards, are appointed by Order-in-Council rather than elected. While the two Alberta Hospitals were administered by the central government, they came under the jurisdiction of the Ombudsman and patients could direct their concerns to him. With the transfer of responsibility for administration to a hospital board (Mental Health Amendment Act, 1981, S.A. Statutes of Alberta, 1981, c. 72), the two hospitals were removed from the jurisdiction of the Ombudsman. A consequential amendment to the Ombudsman Act would have made it clear that a Mental Health Hospital Board is excluded from investigation by the Ombudsman. However, a controversy arose and proclamation of the amending section was delayed pending our study.

Many points can be made in favor of retention of the jurisdiction of the Ombudsman. Involuntary patients are in a position which differs from that of other persons in the health care system. They are there contrary to their own will and are not free to leave at any time. For this reason, there is justification for allocating more avenues of complaint to them than are available to other patients. There is a broad societal concern at the level of the provincial government, the source of authorization for the detention under legislation, to see that the rights of invol-

untary patients are protected and that adequate recourse to forestall or discourage abuse and bad practice should exist. Particularly in the provincial psychiatric facilities, the patient is far more removed from the usual checks and balances of the health care system. He is out of view from the mainstream of society. Visiting is difficult and one would expect that it occurs less frequently than in community hospitals because of the remote location and the nature of the patient population. There is a tendency for the hospital to exist as a community on its own far from outside view and scrutiny.

The Ombudsman has much to offer because of the breadth of his legislative mandate and the fact that it embraces individual complaints. He has the power to initiate investigations, conduct spot tours and so on. He is in a position of influence. His office includes a trained staff with investigative experience. Most importantly, he is independent both of government and of hospital boards so that his investigations would be unhampered by conflicts of interest. As Mr. Justice S.S. Lieberman, now of the Alberta Court of Appeal, said at the Second International Ombudsman Conference held in Jerusalem in 1980:

> The very nature of the 'clientele' under consideration here establishes its greater relative weakness in relation to other elements of society. The mental patient, due to his own limitations and the limitations imposed upon him by society, will often be unable to raise, or incapable of articulating, proper concerns in an effective manner. His relative inability to effectively raise complaints illustrates, at a more limited level, why an Ombudsman must be ever vigilant in this area; in fact, it can be argued that an Ombudsman must be more active in this area than he is in others.

It is crucial that the role of independent investigation of patient complaints be filled by someone, preferably someone with authority and influence, to ensure that the facility is operated in the best interests of the patient and for the protection of the civil rights of those who are involuntarily confined.

The Task Force thinks that all involuntary patients throughout the province whether under observation and assessment at a DF1, or under certificate of admission at a DF2 or DF3, should be entitled to call upon or resort to the services of the Ombudsman.

We considered whether the right of recourse to the Ombudsman ought to be preserved in the case of voluntary patients at the two Alberta Hospitals. These patients also are relatively isolated from the normal checks and balances of a community hospital milieu. Moreover, because psychiatric disorders affect mental processes, their observations and complaints might not be given due credence.

We concluded that mental health care should be assimilated with other health care to the greatest extent possible. This was one reason for putting community boards in charge of the administration of the two Alberta Hospitals. Although the right of recourse to the Ombudsman has existed in the past and has not yet been removed expressly, the Task Force is not convinced that it should be retained for voluntary patients. Voluntary psychiatric patients should enjoy equality with other voluntary patients suffering from any ailment in any hospital.

11.11.2 Internal Hospital Review or Appeal Procedures

A patient may utilize the normal internal hospital review or appeal procedures of a board-administered hospital, now including Alberta Hospital, Ponoka and Alberta Hospital, Edmonton. Ultimately, such procedures will lead him to the hospital board.

We are glad that there are such internal structures to deal with complaints. However, we do not think that this avenue alone can provide patients with sufficient protection of their rights, especially in cases where there is conflict between the interests of the patient and the interests of the hospital.

11.11.3 Alberta Health Facilities Review Committee

The Alberta Health Facilities Review Committee is responsible to visit hospitals and other care facilities and to receive individual complaints.

Again, the existence of this route for complaint is useful but insufficient in itself.

11.11.4 Professional Ethics Committees

Hospital records or similar peer review committees scrutinize medical practices within the hospital. Professional ethics and disciplinary committees regulate the conduct of their professional members. Again, these are valuable avenues of recourse for patients in concert with others.

XII. NOTIFICATION OF RIGHTS

Section 10(a) of the Charter (discussed in Chapter XI) guarantees the right of the patient to be informed promptly of the reasons for his detention. Section 24(1) of the Mental Health Act (also discussed in Chapter XI), requires the patient to be informed of the reasons for his detention and of his right to review. Section 10(b) of the Charter (discussed in Chapter XVI) guarantees the right of a person detained to be informed without delay of his right to retain and instruct counsel.

The Task Force thinks that the patient should be entitled to be informed not only of these rights but also of his other rights under the Act. He should be notified both by written statement and oral explanation. The statement and explanation should be in a language which the patient understands (see section 24(2) of the Mental Health Act and the discussion of the patient's right to the assistance of an interpreter in 11.3). The required explanation should be given upon detention and, if the patient is irrational at that time, again as soon thereafter as the patient becomes capable of comprehension, or upon inquiry by him. This includes notification to a person who entered the hospital on a voluntary basis and is later certified.

The same notification should be given to the patient's nearest relative and a person named as his representative.

We would go even further than this. We would obligate the boards of facilities at all three levels (DF1, DF2 and DF3) to take reasonable steps to ensure that both involuntary and voluntary patients are informed of their rights at all times. Not all rights will be applicable to all levels of facility. For example, the right of an involuntary patient to review by a review panel applies only to detention in a DF2 or DF3. A person detained in a DF1 would be entitled to exercise the right to review by the court which we recommend be added to the Act (see Chapter XIV).

We recommend that a statement of the rights of both involuntary and voluntary patients should be posted in prominent locations in all wards throughout facilities. We further suggest, but do not recommend legislation to require, that a standardized booklet of rights consistent with the Act should be prepared for distribution to involuntary and voluntary patients upon admission. The booklet should also be available on every psychiatric nursing unit.

XIII. REVIEW BY REVIEW PANEL

13.1 Charter Implications

13.1.1 A Fair Hearing on the Merits

The principles of fundamental justice guaranteed by section 7 of the Charter entitle an involuntary patient to a fair hearing on the need for hospitalization. The hearing must be before an impartial tribunal. Section 9, which guarantees the right not to be arbitrarily detained or imprisoned, is to the same effect.

Generally-speaking under our law the principles of natural justice require a hearing to precede detention. However, in urgent situations or where for other reasons it is impracticable to hold a hearing beforehand one may be held promptly afterwards.

The person detained has the right to know the reasons for detention. This right not only entitles him to notification of the reasons and authority for the detention but also to be present at the hearing to hear the evidence presented by the detaining authority, and to have access to his medical records. The principles of natural justice give the patient the right affirmatively to make out the case against detention. This right involves the presentation of evidence and the calling of witnesses. The principles also give him the right to contradict the case for detention. This right embraces the rights of cross-examination and reply. Because existing rights are affected, the decision-making tribunal must find that the criteria for detention have the been met. This is an objective legal standard to which it must adhere in making its decision. It does not have the discretion to decide as it wishes. This point is particularly important in the case of detention for mental disorder because the liberty of a person is at stake and that person has committed no culpable transgression against society.

13.1.2 Continuing Review of Criteria

Under the criteria set out in the *Winterwerp* case, the validity of the continued confinement depends on the persistence of a mental disorder of a kind or degree warranting compulsory confinement. This suggests that it may be necessary to conduct an automatic periodic review of the detention in order to ascertain whether the mental illness still exists in the same magnitude. There are implications here for the provisions governing the renewal of certificates and one might wonder whether the restriction of hearings to one per pair of certificates falls within the reasonable limits of a free and democratic society. Indeed, the *Winterwerp* criteria may have implications which go beyond periodic reviews. It may impose an obligation on the medical staff and in particular the responsible physician to con-

tinually survey the conditions for detention, and to cancel certificates where the conditions cease to exist.

13.1.3 Detention Under the Mental Health Act

In the case of detention for mental disorder, the person presented for examination will be severely ill. The need for prompt medical attention will be paramount and the circumstances such that it will be impractical to afford an antecedent hearing. These two factors permit deviation from the general rule of a prior hearing.

Provision for a hearing after the fact may have the positive effect of enhancing the therapy: a patient may be more likely to accept the hospitalization and treatment if the authority and need for it are substantiated by an independent body before which he has the opportunity to state his own position. Moreover, a physician who knows he may be called upon to explain his medical opinions to an independent tribunal may be expected to take particular care in deciding to issue certificates.

Disadvantages of the deferral of judicial process until after hospitalization include the possible dulling force of detention and treatment on the patient's will and ability to object.

Dr. W. J. Curran, a health law scholar of international renown, commented in Edmonton in June that the international trend in mental health legislation is away from the requirement of a pre-commital hearing in all cases. One notable exception to the trend is the United States. (Dr. Curran, LL.M., J.D., S.M. Hyg., was guest speaker at the Provincial Conference of the Alberta Branch of the Canadian Mental Health Association. He holds the seat of Francess Glessner Memorial Professor of Legal Medicine at the Harvard Medical School.)

The Mental Health Act entitles a patient under certificates to apply for review by a panel appointed under the Act for this purpose. The Task Force agrees with the concept of the review panel but recommends changes in the provisions governing its functioning. Some changes will be required because of our recommendation for the introduction of intermediate periods of compulsory hospitalization at regional psychiatric facilities (DF2's). The system of review panels will need the capacity to respond to applications from patients in many geographic locations. The shorter-term period of compulsory hospitalization, and the demands of justice, both require a capacity for prompt hearings. The panels will need to be mobile and able to respond rapidly.

13.2 Establishment of Review Panels (section 7)

13.2.1 Function (section 7(1)

Section 7(1) requires the Minister to establish review panels to hear applications concerning the cancellation of admission certificates or renewal certificates.

We recommend that the Minister should continue to bear responsibility for the establishment of review panels.

The main function of the review panels should be to hear applications from involuntary patients concerning the cancellation of admission certificates or renewal certificates.

Elsewhere in the report, we recommend an expansion of the functions of review panels to include: review of applications, on behalf of facility boards or other recordkeepers, for permission to withhold a portion of a patient's medical record (chapter XVII); review of treatment to which the patient objects (chapter XV); review of the revocation of a leave of absence, even if the current certificates have been challenged on a previous occasion (chapter XIX); review of a decision to return a patient to a correctional institution (as now under section 29, and see 21.3); and review of a decision to transfer a patient to another facility of the same designation (chapter XVIII).

13.2.2 Composition (section 7(2))

Qualifications of Members

Section 7(2) provides that each review panel shall be composed of a psychiatrist, a physician, a solicitor, (who shall be chairman), and a person representative of the general public.

The Task Force agrees with this composition. The solicitor should contribute his knowledge of the Charter requirements, the patient's civil rights, and the rules of fair process.

The psychiatrist is necessary because questions of mental disorder are being reviewed: his experience and expertise will help the panel to interpret the medical evidence given by the staff psychiatrist or physician who is advocating the detention.

The inclusion of a physician recognizes the role of the physician in commitment, care and treatment of mentally disordered persons at the community level. We considered but rejected the idea of including mental health workers in other professions (e.g. psychologists, social workers, psychiatric nurses) as optional substitutes for the physician on the panel.

The general public representative will assist the panel to strike a fair balance between the interests of society in the patient's well-being and the safety of others, and the interests of the individual in the case. This member should not be a psychiatrist, physician or solicitor, and we recommend that the legislation should make this clear.

Roster of Panelists

The Minister should not appoint individual review panels. He should instead appoint a roster of panelists to each category of membership on a panel. That is, he should appoint a number of lawyers, a number of psychiatrists, a number of physicians and a number of persons representative of the general public. Review panels should then be constituted as needed, from

among the persons named on the roster, to respond to applications.

Mobility

The memberships on review panels should not, as we have said, be fixed. Panels should instead be constituted as required from a roster of persons appointed to each category of membership.

An administrative system to supply review panels when required will have to be devised. It should have the capacity to respond to applications for review in regional (DF2) as well as provincial (DF3) psychiatric facilities. One advantage of the roster system and the consequent variation in the composition of review panels will be the avoidance of any tendency for review panel members to become overly fraternal with medical and other staff. The independence of review panels will, in this way, be better safeguarded. The panels might be comprised on a regional basis to reduce travel distances and accommodation expenses.

Section 7(3) enables the Minister to designate a vice-chairman of a review panel and to appoint one or more alternate members. The roster system of appointment will render this provision unnecessary.

13.2.3 Method of Appointment

Appointment to review panels under the Mental Health Act is a matter for ministerial choice. It was submitted that the respective professional associations should nominate members to the positions of solicitor, psychiatrist and physician. The Task Force rejects this suggestion. We feel that a requirement for nominations would unduly complicate the process.

13.2.4 Term of Appointment (section 8(4))

No term of appointment is specified in the Mental Health Act. Instead, section 8(4) provides for periodic review by the Minister.

We think that the specification of a term of appointment would help to ensure the independence of the tribunal from the central administration. Removal should only be for cause. We also recommend that a five-year maximum be placed on appointments to the panel, so that members remain fresh in their approach. An appointment could be for five years in the first place, or the initial appointment could be for three years, with renewal for two more.

13.2.5 Prohibitions On Membership (section 9)

Section 9(1) prohibits a person who is actively serving as a member of the staff of a facility from sitting on the review panel when it is considering an application from an involuntary patient in the same facility.

Section 9(2) prohibits from membership a person who is related by blood or marriage to the applicant, a psychiatrist or physician who is treating or has treated the applicant, or a solicitor who is acting or who has acted for the applicant.

The Task Force considered whether all members of staff of all facilities in the province should be excluded from membership on any review panel. We came to the conclusion that this degree of caution is unnecessary and that the safeguards now contained in section 9 are adequate.

13.2.6 Additional Protection Against Bias

No two successive applications by any one patient should be heard by the same review panel. A change in the composition of the panel on a subsequent application will help to ensure that its members have not prejudged the issue.

13.2.7 Replacement of Member Who Cannot Act (section 7(3))

Section 7(3) of the Mental Health Act allows a panel member to be substituted during the course of a hearing. The principles of natural justice require the hearing to be held by the person or persons who decide. If a member of the review panel is unable to finish a hearing, the matter should be either continued by the remaining members or reheard by a reconstituted panel. The Task Force recommends deletion of the latter clause of section 7(3).

13.2.8 Quorum (section 8(1))

Under section 8(1) the four members of the panel constitute a quorum. We endorse this number.

13.2.9 Votes (section 8(2))

Section 8(2) entitles each member of the panel to one vote. In the event of a tie, the chairman may cast a second vote. We agree with this provision.

13.2.10 Majority Decision (section 8(3))

We agree with section 8(3) that a decision of a majority of the members of the panel should be the decision of the review panel.

13.2.11 Duties and Powers of Review Panel (section 10(1))

Review panels should have the duty of hearing and considering applications under the Mental Health Act and the Regulations and for that purpose the members of the review panel should have all the powers of a commissioner appointed under the Public Inquiries Act. This is in accordance with section 10(1) of the Mental Health Act.

13.2.12 Provision of Assistance to Review Panels (section 10(2))

Section 10(2) makes the Minister responsible to provide secretarial, legal, consultative and other assistance to review panels as may be required. We recommend that the section should include the responsibility to provide the assistance of an interpreter as required by section 14 of the Charter (Chapter XI. Patient Rights).

13.2.13 Appointment of a Coordinator of Review Panels

To make the roster system of review panelists effective, someone should be named to constitute the panels and to attend to other administrative details. We recommend the appointment of a coordinator of review panels whose functions will be:

- to receive applications for review;
- to set up panels to hear applications, using the roster of appointed members;
- to arrange the date, time and place of hearings;
- to notify the patient, his nearest relative, any representative named by him, and the board of the facility (to enable arrangements to be made for the attendance of the physician) of the date, time and place of a particular hearing;
- to store documentation recording the proceedings;
- to arrange for the publication of decisions after obfuscating any personally identifying information;
- to compile an annual report of review panel activities for the Minister; and to set up an orientation program for newly-appointed review panel members.

Specific recommendations for the performance of several of these functions follow later in this chapter.

13.3 Initiation of Review

13.3.1 Application to Review Panel (section 25(1) and (2))

An involuntary patient or a person on his behalf should be able to apply to a review panel for cancellation of certificates of admission or renewal by sending notice of the application to the coordinator of review panels in the prescribed form. Under section 25(1), the application is sent to the chairman of the appropriate review panel. With the introduction of our roster scheme, however, there will be no single chairman responsible to chair all hearings on applications at a given facility.

Section 25(2) permits the Minister, the Director or a board to submit an application on behalf of an involuntary patient and provides further that reference elsewhere in the Act to the "applicant" should be to the patient and not the Minister, the Director or the board. It should be continued.

13.3.2 Frequency of Review

On Application (section 25(2))

Section 25(3) entitles the patient to make one application for review in respect of each pair of admission or renewal certificates issued. The Task Force recommends that this right should extend to certificates issued at a DF2 and a DF3. (We recommend an exception to the one-hearing principle where a leave of absence is revoked: see 19.1.)

Section 25(3) entitles the Minister, the Director or a board to apply "at any time". We read this to mean that these persons may apply for review "more than once" on a given pair of certificates and we agree with the policy.

The review panel should not lose jurisdiction to hear the application of an involuntary patient because one pair of certificates has expired before the hearing. The Act should authorize the proceedings to be continued on the basis of the certificates that are in force at the time of the hearing.

A patient who withdraws his application prior to decision should not lose his right to apply for review of the current certificates. He should have the choice of bringing the application at a future time.

Automatic

Under the existing Act review must be initiated by an application. The Charter provisions and the principles of fundamental justice may require an automatic review, at least on a periodic basis.

The Task Force does not favor automatic scrutiny of every pair of certificates issued. We fear that hearings would tend to become routine. We would not, however, wish to risk the possibility of extended hospitalizations occurring without review because the patient lacks the initiative to take action and no one submits an application for him.

We therefore recommend that review should be automatic in the case of every patient, involuntary or voluntary, who has been hospitalized for a continuous 180-day period. The 180-day period of hospitalization shall not be considered to have been interrupted or terminated by reason only that the patient has been on leave of absence from the hospital for a part of that time. The requirement of an automatic review is in accordance with recent trends in Canadian mental health legislation.

13.3.3 Speed of Review (section 28(1))

To be effective, review must be prompt. The detention and some medications or other treatments may dull the patient's initiative to seek review, compound his confusion, or otherwise deter him from objecting. Section 28(1) permits 28 days to intervene between receipt of the application and the hearing

on it, with the possibility of an extension of the time by the Minister. Coupling this period with the chairman's power under section 27(5) to adjourn a hearing for up to 21 days worsens the situation. Twenty-eight days is far too long.

We think that the applicant should be notified of the date, time, place and purpose of the hearing within 7 days from the date the application is received by the coordinator of review panels. The hearing should be scheduled no later than 14 days after the application is received. The applicant should have 7 clear days notice before the hearing to notify his witnesses, if any, and otherwise to prepare his case.

The power of the Minister to consent to an extension of the time for hearing beyond the 28-day period is inappropriately placed and should be deleted.

13.4 Preparation For Hearing

13.4.1 Notice of Hearing (section 26(1))

Section 26(1) directs the chairman of the review panel to give notice of the date, time, place and purpose of the hearing to the applicant and any persons acting on his behalf, the nearest relative, and any other persons the chairman considers may be affected.

The Task Force recommends that the coordinator of review panels should send out the initial notices. The patient and any person acting on his behalf should have at least 7 clear days in which to prepare his case. Notice should be given to the board of the facility in which the patient is detained in order to allow arrangements to be made for the attendance of the responsible physician at the hearing. The physician is a necessary witness and if he is reluctant to attend or the board neglects to contact him the chairman should use his power, as a commissioner of public inquiry, to subpoena the physician to attend. Notice should go to the medical director of the facility to enable him to instruct his staff concerning the effects of treatment on the patient's presentation before the review panel (see 13.4.5: Condition of Patient at Time of Hearing). The nearest relative and the person named by the patient as his representative, if any, should receive notice. Any other person whom the chairman considers may be affected by the application should also be notified.

13.4.2 Investigation by Review Panel (section 26(2))

Section 26(2) directs the review panel to carry out whatever investigation and hearing it considers necessary. It adds that the panel "may invite" the applicant or any other person to testify or produce evidence.

We find it undesirable to characterize the nature of proceedings before the review panel as adversarial or inquisitorial. The proceedings should be specially designed to meet the unique characteristics of this situation.

First and foremost, the proceedings should be conducted in a judicial manner. The patient is a necessary participant in the proceedings. He should enjoy the full safeguards accorded by the principles of natural justice. The principles of natural justice would give him the right to attend and participate as a party at the hearing, not merely to be invited by the review panel.

At the same time, review panels should continue to have full powers of investigation for the purpose of gathering in all relevant evidence and deciding cases correctly. The power of a review panel to investigate partially compensates for the obstacles which inhibit a patient from making his case.

13.4.3 Documentation Before Review Panel

Several documents should be before the review panel:

(1) the detaining certificates;

(2) the application for review;

(3) a summary of the patient's medical records prepared by a member of the staff of the facility, backed up by the review panel's right of access to the original records (see Chapter XVII: Patient Records and 13.4.4 below);

(4) a report prepared by the physician responsible for treatment of the patient in the facility summarizing

  (a) the current mental condition of the patient,

  (b) his present treatment and treatment plan with particular reference to any treatment which is likely to affect the patient's appearance, demeanour and level of functioning at the hearing, and

  (c) the reasons why the physician thinks that the patient still satisfies the criteria for compulsory hospitalization;

(5) a home circumstances report prepared by a social worker or other member of the hospital staff; and

(6) a statement of any investigation conducted by the review panel prior to the hearing and of its findings.

The home circumstances report is important because it is not the patient's dangerousness in the hospital environment that is tested by the criteria as much as his anticipated conduct in the community. Consideration of the circumstances into which the patient would be released were his certificates to be cancelled is relevant to this determination.

We believe that the results of any independent investigative steps taken by the review panel should be disclosed to the patient. The principle of disclosure should govern investigations, if any, made before or during the hearing.

Full disclosure is important to the patient's right to meet the case for detention.

13.4.4 Access by Patient to Documentation Before Review Panel

Our principle is that the patient should have access to all documentation and other evidence before the review panel. He should have the right to see and comment on anything written, and to hear and comment on anything said at the hearing.

We do, however, recommend an exception to the principle where disclosure of information on the record might seriously endanger the safety of a third person. The decision to withhold a portion of the record from the patient should be made by the review panel on the application of the responsible physician or any other person in charge of the records who objects to the release. (For further details, see Chapter XVII: Patient Records.)

13.4.5 Condition of Patient at Time of Hearing

The treatment regime may interfere with a fair hearing. For example, a recent increase in dosages of a major tranquilizing drug may make the patient unduly sluggish at the hearing. Other changes in medication close in time to the hearing may also alter the patient's condition in a way detrimental to his presentation before the panel. Similarly, the scheduling of ECT just before the hearing would leave the patient in a state of confusion at the hearing. Ironically, the decision to change the treatment may be in response to the patient's state of growing anxiety as the hearing draws near.

Medications or other treatments should not be used for the purpose of adversely interfering with the patient's ability to recognize his status and contest the detention nor should they unduly inhibit the patient's ability to comprehend and participate in the hearing before the review panel.

In the case of a patient who applies for review immediately after admission into hospital, it would be best if no drugs at all were administered prior to the hearing. If it has been necessary to administer drugs their use should be limited solely to those deemed by the attending physician to be medically essential to reasonable management prior to the hearing.

Where the patient has been hospitalized for a longer period, he should be in the best possible condition to comprehend and present himself at the hearing. The review panel should get an accurate idea of how he functions under optimum treatment. He should not be excessively drugged or tranquilized. The treat-

ment program should not be compromised by the hearing, but the hearing before the panel must at the same time be a fair one.

The source of the problem, insofar as it exists, appears to be poor communication between review panels and medical staff. We recommend that notice of an impending hearing should be given to the medical director. The medical director should then bear the responsibility of instructing his staff to refrain from introducing any major changes in treatment before the hearing.

At the commencement of each hearing the chairman should ask the responsible physician what medication the patient is on, what its effects are, and whether or not there have been any recent changes. The review panel should also examine the medical chart on the patient's record for recent changes in the quantities or combinations of medication, or in other treatments, administered to the patient.

It should be the responsibility of the chairman of the review panel to inform the medical director of the facility if problems do occur.

The details of our recommendation should be worked out in consultation with hospital medical staff and review panel members, and promulgated by regulation.

13.5 Conduct of Hearing

13.5.1 Representation of Patient (sections 26(1), 27(2))

The applicant should be able to be represented by a person who is not necessarily a lawyer but who will speak on the applicant's behalf. Such a person is contemplated by the requirement of notice:

(1) under section 26(1), of the date, time, place and purpose of the hearing to "any person acting on his [the patient's] behalf"; and

(2) under section 27(2), of the right of the applicant "and his representative" to be personally present during the presentation of any evidence.

The right to be represented by a lawyer is discussed in Chapter XVI: Patient Advocacy.

13.5.2 Conduct of Review in Private (section 27(1))

Section 27(1) provides that all proceedings of a review panel shall be conducted in private. With the exception of the applicant and his representative, no person may be present without the prior consent of the chairman.

Legislation in England gives the patient the option of requesting a public hearing. The Task Force is attracted to this idea and recommends that the hearing should be held in private except where the patient requests that it be held in public. The effect of this will be to allow any member of the public to be present at the hearing if the patient desires it. The review panel should not have the discretion to exclude members of the public when the patient wants them to be present. As the English Commission which originally recommended the review panel system observed, "Publicity or the possibility of public report is a strong safeguard against abuse of compulsory powers, and when it is not detrimental to the proper interests of the patient and of other people it is to be welcomed" (*Royal Commission on the Law Relating to Mental Illness and Mental Deficiency* 1954-57 ("the Percy Commission"), Cmnd. 169 (1957) at 151).

In cases where the hearing is conducted in private, the chairman should continue to have the right to give permission to persons to be present during the hearing.

13.5.3 Power to Exclude Patient From Hearing (section 27(2))

Section 27(2) enables the patient to be excluded from the hearing "if in the opinion of the review panel there may be an adverse effect on the applicant's health by his presence". In this event, the review panel is required to appoint a person to act on the patient's behalf if he does not already have a representative.

The Task Force strongly disapproves of the power of the review panel to exclude the patient from the hearing. Its use would infringe the patient's fundamental right to hear the evidence put forward in support of the detention.

We recommend the repeal of this power.

13.5.4 Formality of Hearing

The atmosphere of the hearing should be dignified and solemn. Persons participating in the hearing should be at ease but within well-defined limits commensurate with the gravity of the occasion and the seriousness of the issue being determined. The impartiality and objectivity of the panel should not be jeopardized by undue familiarity with any of the participants. It is important that the development of the hearing and the presentation of evidence occur in an orderly fashion. The possibility of bias in either appearance or fact should be studiously avoided.

Having said as much, we nevertheless favour the relaxation of normal court practices to some extent. It is appropriate for hearings to be held on hospital premises for the convenience of the patient and of the hospital staff. A conference-style arrangement of the furniture for the hearing would be suitable.

Moreover, there need not be strict adherence to the rules of evidence.

At the same time, all participants in the hearing must understand its purpose, the order of procedure and their own roles in it. The patient should be aided as much as possible to comprehend the process which he has activated.

The formality and procedure of the hearing should be part of the orientation program which we recommend be held for review panel members (see 13.10).

13.5.5 Swearing of Evidence

The powers of a commissioner appointed under the Public Inquiries Act include the power to require witnesses to give evidence on oath. We understand that under present practice this power is seldom used. We think that it would be preferable for evidence to be sworn at the hearing. The requirement would add to the tone of solemnity of the proceedings and impress upon witnesses taking part the importance of telling the truth. The patient, however, should not be precluded from testifying on the basis that there is doubt as to his competence to swear an oath. The patient should be permitted to testify unsworn in this circumstance.

13.5.6 Presentation of Evidence (section 27(3))

Patient or His Representative

Section 27(3) gives the patient or a person acting on his behalf the right of cross-examination. This is the only right relating to the presentation of evidence given to him under the present Act. Section 26(2) permits the chairman to invite any other person to testify or produce evidence. This provision indicates that the conduct of the proceedings is very much in the hands of the chairman.

The Task Force thinks that the patient should enjoy all the benefits of natural justice to which he would be entitled as a party in a civil suit. The principles of natural justice require that the patient should have an opportunity affirmatively to present his case against detention as well as to contradict the case for detention. To present his affirmative case at a hearing, he should be able to introduce both oral and written evidence. To contradict the case against him, he should continue to have the right of cross-examination and he should have the right to reply to the case for detention.

If the patient has a representative, the representative should be able to exercise the patient's rights on his behalf.

The chairman of the review panel should use his power, as a commissioner under the Public Inquiries Act, of summoning witnesses who can give relevant evidence where the patient requests that he do so.

Responsible Physician

The testimony of the physician responsible for the care and treatment of the patient at the facility is necessary evidence and the chairman should be required to secure his attendance, using the power to compel if necessary. Notice of the proceedings and that the physician's testimony is required should be sufficient in most cases.

The physician should not be a party to the proceedings in an adversarial sense, although his opinion will be opposed to that of the patient seeking review. He should give his evidence in an objective, professionally competent manner. It would be entirely inappropriate, for instance, to allow him to assume a prosecutorial stance. It should be the members of the review panel who question the patient to clear up discrepancies or shed more light on matters.

Other Persons

The review panel should continue to be able to notify any other persons from whom it wants to hear and have them come and give evidence, as it now may under section 26(2).

13.5.7 Order of Evidence

Notwithstanding our recommendations for a permissible degree of informality in the proceedings, we believe that the evidence should be presented in an orderly manner. We propose the following order:

(1) verification of the patient's present condition by review of the patient's medical record and questioning of the responsible physician about medication and other treatments;

(2) adducement of a statement from the responsible physician;

(3) presentation of the patient's case including his response to the statement of the physician;

(4) testimony by the patient's witnesses, if any;

(5) testimony by relatives or other interested persons;

(6) response by the responsible physician;

(7) reply by the patient;

(8) summing up and argument;

(9) departure of the participants;

(10) deliberation and decision by the review panel.

Each member of the review panel should have an opportunity to ask questions of each witness. The patient or his representative should have a right to cross-examine other witnesses on their testimony.

The order of presentation of evidence should not be inflexible. The Task Force does not recommend that it be solidified in legislation. We do, however, recommend that it should be included in the program of orientation of review panel members.

13.5.8 Power of Review Panel to Order an Independent Medical Examination

The Task Force has recommended that the patient should have the right to obtain, at public expense, one medical opinion from a physician of his choice practicing in Alberta. He may obtain as many medical opinions as he wants from any physician practicing anywhere at his own expense (see 11.5).

In a rare case, the review panel may not be fully satisfied with the medical evidence before it. We therefore recommend that it should be able to request that the patient submit to an examination by a independent physician or psychiatrist whom it names. The review panel should assume the cost of any examination which it requests.

13.5.9 Burden of Proof

The question of who should have the burden of proof under the provisions of the Mental Health Act in British Columbia is considered in the cases of *Re Robinson and Hislop,* 114 D.L.R.(3d) 620 (B.C.S.C.), and *Re Hoskins and Hislop,* 121 D.L.R.(3d) 237 (B.C.S.C.). Both cases find that the onus is on the director of the detaining facility and that the director bears the normal civil onus. In other words, the case for detention must be shown on a preponderance of the evidence.

The Task Force agrees that the burden of proving that the patient meets the criteria for hospitalization should lie on the facility detaining him. The evidence will, of course, be given by the physician who is caring for the patient. If the case for confinement is not made out the patient should be released.

In the case of *Re Hoskins and Hislop* it was further held that, under the British Columbia statute, although the onus of proof should be on the director of the facility the petitioner must first raise a prima facie case for the director to answer. We do not agree with this position. We recommend that there should be no requirement on the patient to first make out a prima facie case against his detention. The absence of such a requirement should be legislated to avoid the British Columbia result.

13.5.10 Power to Adjourn (section 27(5))

Section 27(5) of the Mental Health Act gives the chairman power to adjourn a hearing for any period up to 21 days for any purpose he considers necessary. This time may be extended with the consent of the Minister.

The Task Force thinks that the chairman should continue to have the power to adjourn the hearing for any reasonable time up to 21 days. The power should be used sparingly and in consideration of the patient's interests, given that a prompt hearing is the primary goal. The chairman should be able to adjourn on as many occasions as fairness dictates where the patient applies for the adjournment. However, he should not adjourn more than once on the request of anyone else. (See 13.6.2 for our recommendations for the conferral of an extended power to adjourn in special circumstances.)

As we stated with respect to the power to extend the time within which the hearing must be held (see 13.3.3), we think the involvement of the Minister in permitting extended adjournments is inappropriate and we would remove this power.

13.6 Disposition

13.6.1 Cancellation of Certificates (section 28(2)(a))

Section 28(2) empowers the review panel to cancel the admission or renewal certificates authorizing the detention, or to refuse to cancel the certificates either with or without conditions.

The Task Force believes firmly that when the criteria for issuance no longer exist, the certificates should be cancelled and the patient released unless he is willing to continue treatment on a voluntary basis. Our position is consonant with the criteria set down by the European Court of Human Rights in the Winterwerp case. That case stipulated that the detention may be sustained only as long as the mental disorder continues to be as severe as it was to warrant detention in the first place. The review panel does not enjoy an unfettered discretion to decide as it wishes. To the contrary, it has a judicial obligation to apply the objective test for hospitalization set out in the Act.

We recommend that where the review panel is of the opinion that the patient no longer poses a danger to himself or others, or that the mental disorder has been cured, it should be obliged to cancel the certificates.

The review panel should have the power to delay, for up to 2 weeks, the discharge of a patient whose certificates have been cancelled to allow time for hospital staff to make suitable aftercare arrangements. This recommendation is based on the 1982 addition of section 123(1B) to Britain's Mental Health Act 1959 to permit the patient to be discharged on a future date specified in the direction.

The determination whether the patient is still in a condition posing a danger to himself or others is a difficult one. The patient may be doing well in the hospital setting, but how he

will fare in the community is unknown. His dangerousness may be a product of a specific situation, or of a certain circumstance.

Where the review panel feels that the patient's condition has improved but is uncertain about cancellation of his certificates, it should be able to let the patient test himself in the community.

We make recommendations to facilitate a trial period in the community in 13.6.2.

13.6.2 Refusal to Cancel Certificates (section 28(2)(b))

As amended in 1981, section 28(2)(b) permits a review panel to refuse to cancel certificates "with or without conditions".

The possibility of imposing conditions raises a number of questions. What conditions may it set? On whom may they be imposed: the patient? the facility? the physician? anyone else? How long do the conditions remain in effect? What are the sanctions if the conditions are not met?

The Task Force sees no worthwhile purpose to be served by allowing the review panel to refuse to cancel certificates with conditions. We recommend that where the review panel is of the opinion that the criteria for hospitalization are present, it should be obligate to refuse cancellation of the certificates. No conditions should be attached to the refusal.

The review panel may, on the other hand, be uncertain how the patient will behave in the community. Will he be dangerous in the environment into which he is released? If medication is necessary to maintain his improved condition, will he take it?

In the analogous case of an involuntary patient who has not asked the review panel to cancel his certificates, section 38(1) empowers the medical director to grant a leave of absence. Section 38(2) enables the medical director to attach terms and conditions to the leave. These "may include a condition that the involuntary patient remain under the supervision and subject to the treatment of any person or persons authorized by the medical director". Another condition could be that the patient take his medication while in the community.

We think that in a proper case, the patient should be allowed to test his ability to cope in the community. The chairman of the review panel should use his power of adjournment to enable the medical director to exercise his discretion to grant a leave of absence under section 38. Adjournment would be appropriate where the review panel is not convinced that the patient's certificates should be cancelled, although he appears to be making good progress in this direction.

The initial period of adjournment should not be more than 21 days. If the medical director has not granted leave within this time, the review panel should proceed with the hearing and decide about cancellation. If he has granted leave, the adjournment should be automatically extended for the duration of the

leave. If he subsequently revokes the leave, the matter should be returned to the review panel for hearing and decision.

The leave and any conditions attached to it would necessarily expire with the certificates. The outside limit of the operation of conditions would be 180 days, the longest period of renewal allowed under our recommendations.

13.6.3 Reasons for Decision

Section 28(4) of the Mental Health Act refers to "the written report of the decision of the review panel". It does not say that reasons for the decision must be given. The decision could simply be to cancel or refuse to cancel the certificates in question and the written report could say only that.

A requirement to give reasons would have many advantages. The process of formulating reasons would tend to protect review panels from making careless or hasty decisions. They would be impelled to make sure that the main facts and ideas had been considered. Where cancellation of the certificates is refused the reasons would assist the applicant in deciding whether there are grounds for an appeal.

If the reasons for decisions were published (see 13.8), they would set precedents for certification thereby guiding the actions of mental health personnel in future cases. They would also lead to like dispositions in like cases, an important consideration under our recommendations for variable composition of review panels.

The Task Force recommends that review panels should be required to give written reasons for decisions.

13.6.4 Notice of Decision (sections 28(3), 28(5))

Section 28(3) requires the chairman of the review panel to send a copy of the decision to the patient within 7 days of the decision. Although the decision is likely to be made on the date of the hearing, there is no requirement that the date of the decision concur with the date of the hearing. To avoid any discrepant result, the Task Force recommends that the section be rewritten to require the decision to be given to the applicant within 7 days of the hearing.

Section 28(5) requires the chairman to give a copy of the written report of the decision to the Minister, the Director or a board where one of these persons initiated the application. We recommend the continuation of this provision.

13.6.5 Notification of Right to Appeal (section 28(4))

Section 28(4) requires the written report of the decision of the review panel to include a statement of the right of the applicant to appeal the decision to the Court of Queen's Bench where the review panel refuses to cancel the detaining certificates.

The Task Force agrees with the intent of this provision. We recommend, however, that the statement should include the information that the applicant has 14 days from the receipt of the decision to launch the appeal. The notification of the right to appeal should be given in writing and served together with the review panel's decision and reasons.

13.6.6 Duty of Board to Comply With Decision (sections 28(6), 34(1))

Section 28(6) directs the board of the facility in which the involuntary patient is detained to take whatever action may be required to give effect to the decision of the review panel. Section 34(1) is similar in compelling the board to comply with and take any necessary action to comply with a decision of the review panel concerning certificates.

We recommend retention of this duty.

13.7 Record of the Proceedings

The Mental Health Act is silent about the obligation of the review panel to maintain a record of the proceedings taken before it.

The Task Force recommends that the chairman of the review panel should be responsible to ensure that a record is maintained and to forward it, upon completion of the review proceedings, to the coordinator of review panels for preservation.

The record should consist of all documentation before the review panel (see 13.4.3), a transcript of the hearing maintained in accordance with the Mechanical Recording of Evidence Act, the decision, the reasons for the decision, and the names of persons to whom the decision is forwarded.

The record should be available, on request, to the patient, the person named by the patient as his representative and his legal counsel, if any.

13.8 Publication of Proceedings (section 27(4))

Section 27(4) prohibits the publication of "a report of a hearing, investigation or deliberation by a review panel or the names of any persons concerned therewith", except with the permission of the chairman or when the publication is made by the applicant or his representative.

In cases where the patient requests that the hearing be held in public, we see no reason for placing a stringent restriction on publication. As a general rule, personal identities should be protected from disclosure in any publication of the proceedings. If the patient requests that names be published the review panel should be able to permit it where disclosure would not be injurious to the personal interest, reputation or privacy of the persons involved.

In cases where the proceedings are held in private, section 27(4) should continue to apply to the proceedings themselves. It should not apply to

the publication of the reasons of the review panel for decisions. In our view, the Mental Health Act should require reasons to be published for the purpose of building up a body of law to which mental health personnel issuing certificates, facility boards contemplating discharge, and patients seeking review may turn for guidance. The personal identities of the patient and of other persons participating in the proceedings whose personal interest, reputation or privacy may be harmed by publication should not be disclosed in the published decisions.

Publication should be the responsibility of the coordinator of review panels.

13.9 Additional Powers of Review Panel

13.9.1 Scrutiny of Withdrawn Applications

There is a high rate of attrition on applications for review. At Alberta Hospital, Edmonton, approximately 25 applications are commenced each month, but only 88 hearings were held in 1982. Some patients may be discharged before the hearing is scheduled. Others may assume voluntary status. However, the Task Force has been led to understand that persons are sometimes discouraged by the friendly persuasion of well-meaning, but misguided, hospital staff from proceeding with their applications.

A good advocacy program should curtail withdrawals on this specious basis. The scrutiny of withdrawn applications is, nevertheless, compatible with the fulfillment of the review panel's investigative function. We recommend that a review panel should have the power to inquire into the reason for the withdrawal of an application and to proceed with the hearing if the applicant wishes it.

13.9.2 Hearing of Applications to Withhold Portions of Patient's Record

The Task Force recommends, in chapter XVII, that the patient should have a general right of access to his medical record, subject only to an order by the review panel permitting parts of the record to be withheld where disclosure would jeopardize the security of a third person. The proceedings before the review panel would be brought by the application of the person who is reluctant to make the disclosure.

13.9.3 Review of Treatment Where Patient Objects

In chapter XV, the Task Force recommends that an involuntary patient who objects to the treatment being given to him may make application to the review panel for a review of that treatment and an order that the treatment be discontinued. We also recommend a role for the review panel in decisions to perform psychosurgery.

13.9.4 Review of Decision to Transfer Patient

Section 29 permits a person convicted of a criminal offence who is sent to a facility for treatment to apply to the review panel for an order transferring him back to a correctional institution. The Task Force recommends the continuation of this section in its present form.

We recommend in chapter XVIII that a patient who objects to a decision to transfer him to another facility of the same level should also be able to apply for review of the decision by the review panel.

13.10 Orientation of Review Panel Members

Many matters pertaining to the purpose of review panel hearings and the proper manner of conducting them do not lend themselves to legislative attention. The Task Force strongly recommends the introduction of an orientation program for review panel members. The program should educate members to the gravity of their task, and the importance of performing it judiciously.

13.11 Annual Report to Minister

We recommend that the coordinator of review panels should be responsible to compile an annual report of the activities of review panels during the preceding year for presentation to the Minister. The Minister should be required to table the annual report in the Legislature within twenty days after it is presented to him if the House is sitting and, if it is not then sitting, within twenty days of the commencement of the next sitting of the House (see Hospitals Act, R.S.N.S. 1967, c. 249, s.61).

The report need not give an account of individual cases nor shall it identify patients. Instead, it should contain comment on any matters having to do with the operation of the review panels of which the Minister should be advised – where the system is working well and where improvements need to be made. It should include discussion of the appointment of panels; arrangements for hearings; notification to participants of the date, time and place of hearings; the publication of decisions; and the orientation of newly-appointed members. It should give statistics on the number of applications made, the purposes of the applications, the number of hearings held and their respective dispositions.

13.12 Appeal from Decision of Review Panel (section 32)

Section 32(1) permits the applicant to appeal a decision of the review panel to the Court of Queen's Bench.

It is unusual for a right of appeal to be limited to one party involved in proceedings. The limitation here is a consequence of the unusual nature of the review proceedings. Although the detaining facility must make out the case for detention, it is not a party to the proceedings in a strictly

formal sense. If the facility were to be granted a right of appeal, an adversarial or even prosecutorial tone may develop. This would be highly undesirable. It is conceivable that the board of the facility or the Minister might want to establish a point in principle for the guidance of review panel on future applications. The Task Force would be opposed to the establishment of any such proceedings which are detrimental to an individual patient. Section 32(1) should not be altered.

Section 32(1) requires the appeal to be brought within 14 days of the decision of the review panel. We recommend that measurement of the 14-day period should commence from the receipt of the decision by the patient.

Section 32(5) allows the court to hear further evidence adduced by the "applicant, the Minister or the Public Trustee". We believe that specific reference should be made here to the evidence of the Public Guardian and the board of the facility.

Section 32(8) empowers the court to quash the decision of the review panel and order the cancellation of the certificates, remit the matter to the review panel for reconsideration or make any other order it considers just.

We agree that the court should have the power to uphold the decision of the review panel or to quash it. The Task Force does not think, however, that the power to make any other order the court considers just should be among the options. We would require the court to make a decision about the cancellation of the certificates first.

We do not see any reasonable purpose to be served by allowing the court to remit the decision to the review panel for reconsideration. We recommend the repeal of this power.

The Task Force is otherwise content with section 32 in its existing form.

XIV. REVIEW BY COURT

14.1 Statutory Right of Review

Section 27 of the British Columbia Mental Health Act, R.S.B.C. 1979, c. 256, permits a detention to be challenged by a court application which seeks an order (1) prohibiting admission before it occurs, or (2) compelling discharge. To assist the court in reaching its decision, the director of a designated mental health facility may be ordered to obtain an independent medical opinion from a physician who is recognized by the College of Physicians and Surgeons as a specialist in psychiatry. The adoption of a similar provision in Alberta was advocated by the Criminal Trial Lawyers Association.

A court application offers the possible advantage of speed. Unlike the review panels, which are structured for expeditious, but not immediate, response the court has the machinery to act quickly. The periods of up to 72 hours for conveyance to a facility, and of up to 96 hours for observation and assessment, could be the subject of court application. The introduction of a right to review by the court would be in harmony with the Charter.

We recommend that there be a statutory right of review by the Court of Queen's Bench. The right should be in addition to the right of review by a review panel.

The court should have the authority to prevent a detention before it occurs (e.g. after the issue of a certificate of admission to a DF1 but before apprehension for conveyance pursuant to it); to delay it until a hearing has been held; to cancel certificates which have been issued; or to refuse to cancel certificates, in which case their authority would continue in effect.

The application should be available to the person under detention or whose detention is sought, a near relative or, as in British Columbia, to anyone who believes that compulsory hospitalization is not justified. It should be commenced by an originating notice supported by an affidavit of the applicant setting forth fully all the facts in support of the application. The Court should hear the application on its merits. In doing so, it should be able to review all papers relating to the detention and to hear any further evidence it deems relevant.

As in British Columbia, the Court should be authorized to order an independent medical opinion at public expense by a psychiatrist of the Court's choice. This would be in line with the independent medical opinion which we recommend may be authorized by a review panel (see 13.5.8).

14.2 Habeas Corpus

Section 10 of the Charter guarantees to everyone the right on detention

(c) to have the validity of the detention determined by way of *habeas corpus* and to be released if the detention is not lawful.

It enshrines the common law right to challenge the validity of the detention before a superior court. *Habeas corpus* would lie where the formal validity of the certificates is in doubt (e.g. that they are issued by qualified physicians and properly completed). However, it does not enable the court to review the merits of a decision where the legislation in question (i.e. the Mental Health Act) names an administrative authority (i.e. the review panel) to conduct the review.

If section 7 of the Charter is interpreted to allow substantive as well as formal issues to be raised, it will provide a greater safeguard.

Habeas corpus must, nevertheless, continue to be available as the Charter requires. We recommend that the right to apply for an order in the nature of *habeas corpus* should be specifically preserved in Alberta's Mental Health Act as it is in section 27(2) of the British Columbia Act. That section specifies:

> Nothing in this section [i.e. the section conferring a statutory right of review by the court] affects the right of a person to apply for a writ of habeas corpus or other prerogative writ.

The importance of the provision is to preserve the right to prerogative relief at common law. Otherwise the statutory right of review may be interpreted as an attempt to replace it.

XV. TREATMENT

15.1 Introduction

For the purpose of this report, we are grouping a large number of issues under the heading of "treatment" in the belief that all of these issues relate to one another and that to a certain extent the recommendations depend upon each other for their justification.

We start out with certain basic premises upon which our recommendations relative to treatment are based. To a large extent, it will be a precondition to the successful implementation of our recommendations that adequate facilities and personnel be made available. We do not have any expertise in establishing what these should be in detail, nor do we see this as a part of our terms of reference. However, the underlining recommendation to everything – without which no Mental Health Act can work properly – is that sufficient facilities be made available.

The first issue is whether or not involuntary patients have a right to receive treatment and whether or not that treatment must be of a certain minimum standard.

We must also determine whether or not and to what extent involuntary patients can participate in treatment decisions. For example, what happens if there is a conflict between patient wishes and sound medical judgment?

Lastly, there is a perplexing and almost insoluble problem of adapting the legislation to those who can be most effectively treated within a community, but who refuse such treatment.

It is necessary to offer an explanation of what we mean when we refer to "treatment". For the purpose of this portion of the report, we are limiting the meaning of "treatment" to the active medical steps intended to combat disease or disorder including investigative procedures aiding diagnosis. So, for example, when we discuss the right of a patient to withhold his consent, we are not referring to his rights respecting non-treatment aspects of the problem such as restraint.

15.2 The Right To Treatment

It is the view of the Task Force that the current Mental Health Act is unsatisfactory in dealing with this issue.

Section 13(1) of the current Mental Health Act reads as follows:

> 13(1) On the admission of a patient to a facility, a Board is under a duty to provide the diagnostic and treatment services a patient is in need of and that the staff of the facility is capable and able to provide.

By limiting the obligation of the facility to provide only those services that it "is capable and able to provide", the Act is not really imposing any obligation on the facilities. Presumably, the common law obligation

upon a hospital to avoid negligent conduct is the only treatment standard.

The detention must have a therapeutic result or purpose. Hospitals should not be used simply to remove dangerous people from society when they cannot or will not be treated. As the Alberta Psychiatric Association states in its submission:

> There is no justification for involuntary hospitalization without treatment for the illness that caused the hospitalization. To do so would be to turn the hospital into a jail, and to make a mockery of everything that the ethical physician holds as valuable.

The Canadian Mental Health Association states similarly:

> It is unclear under the present Act whether the intention of the Act is that persons who are dangerous and suffering from a mental disorder are to be detained for the purpose of removing a danger from society or whether such persons are detained for the purpose of effecting treatment, dangerousness merely being the criterion used to determine when involuntary treatment is warranted.
>
> Our position is that there can be no justification in forcibly detaining the person.. without creating corresponding obligations to provide treatment..

The Task Force believes that the right to contemporary and competent treatment is a legitimate *quid pro quo* to the deprivation of liberty resulting from a commitment against the patient's wishes. This principle has already been discussed (see 6.4). By it, we mean treatment that exceeds the minimum standards established in the Regulations for facilities.

In principle, we detected no opposition to this position in the submissions. In practice, however, it should be understood that the implementation of this right in legislation may be difficult in view of the potential magnitude of costs and reorganization involved. The recommendation will no doubt be difficult and expensive to implement.

15.3 Control of Treatment Types

Recent amendments to The British Mental Health Act introduce a Commission with responsibilities in relation to overall treatment practices and standards. These responsibilities included classifying treatments under the Act for the purpose of saying what protections or additional safeguards must be employed before certain of the more risky or extreme treatments may be resorted to. The Canadian Mental Health Association submitted that a Mental Health Board, with broad powers in the same general area, should be established in Alberta and include a treatment standards committee which would function in this capacity.

There are two aspects to this problem, namely:

(1) are sufficient precautions being taken to ensure that all permitted treatments are medically sound?

(2) notwithstanding the soundness of such treatments from a medical

point of view, are we to permit treatment which patients refuse to consent to, and if so, on what basis?

In our view, the first component is solely a medical question and we see no point in having lay persons participate in the setting of standards for what has become a highly specialized and technical area of medicine. In this respect, we propose to treat psychiatry in the same fashion as other branches of medicine insofar as it has the ability to set its own standards.

Without commenting on the advisability of any particular set of standards, we have in mind the benchmark standards established by The American Psychiatric Association as an example. Compliance with such standards should and could be controlled by:

(a) the medical staff review committee and hospital record review committee of each hospital;

(b) the College of Physicians and Surgeons as part of the normal complaint procedure.

We believe that the involuntary patient's position will be further safeguarded by the independent psychiatric opinion which we have recommended (see 11.3) as well as by the right to object to treatment, assisted by the advocacy service, which we recommend (see 15.4).

We appreciate that much of the above adopts the medical profession's traditional solution to safeguarding the quality of care. Possibly an argument can be made that something more formal should be implemented to reflect the care that should be employed before treating patients against their will.

The answer may be that if any profession will not properly govern itself, then the state may have to step in. We do not see any evidence necessitating such a step at this time.

The other aspect of this problem is the question of consent, which we will now address.

15.4 The Question of Consent To Treatment

The Task Force is not entirely satisfied with the current legislation respecting the necessity or lack of same for the consent of patients.

The Act currently provides that in the case of an involuntary patient, the issuance of an admission or renewal certificate is sufficient authority to observe, examine, care for, treat, control and detain the patient (see 7.3.3 and 7.4.3). Although it does not appear to be entirely clear from doubt, it is generally felt that all of this may be done notwithstanding a refusal to consent or the withholding of consent on the part of the patient.

We are not prepared to make consent a precondition to treatment. However, the current legislation fails to take into account the following factors:

(a) in many cases, mentally ill persons, even those who fulfill the current and proposed criteria for admission, are mentally competent to consent or withhold consent; and

(b) in many cases from a medical point of view, it is very important that a patient participate in treatment decisions through some sort of consultative procedure.

The Task Force, therefore, believes that some weight, but not conclusive weight, should be given to the patient's wishes regarding treatment. We propose to give involuntary patients a "right" to object to treatment. The patient should be able to object to medical treatment irrespective of his competence or incompetence in law. Objection should also be able to be taken on his behalf by a near relative, a person named by him as his representative, any physician or a member of the advocacy service (see ch. XVI).

Should an objection occur, we believe that the proposed treatment should only be proceeded with after certain procedural safeguards have been complied with. In this regard, we recommend that upon objection:

(a) the patient should, within a reasonable period of time, have a right to obtain an independent psychiatric opinion paid for by medicare;

(b) if the attending physician wishes to proceed with the proposed treatment, he should apply to the review panel for a hearing to determine whether or not the patient's objection to treatment should be overridden. In considering this question, the review panel should override the objection only upon being satisfied after hearing the evidence of the attending physician, a staff psychiatrist, and an independent psychiatrist, if any, that:

i) each has examined the patient;

ii) they are of the opinion that the mental condition of the patient would be or is likely to be substantially improved by the specific psychiatric treatment or course of psychiatric treatment proposed;

iii) that the mental condition of the patient will not likely improve without the specific course of treatment proposed;

iv) that the proposed treatment will render the patient less dangerous, and;

v) that any alternative treatments are less adequate.

The above is similar to the provisions contained in The Ontario Mental Health Act.

We considered making a distinction between patients who are legally competent to consent to medical treatment and those who are not. The Ontario Mental Health Act, which requires the prior consent of the patient to treatment, makes provisions for obtaining lawful consent from the nearest relative of patients who are incompetent to consider the question of consent.

This procedure of course requires a finding of incompetence before the proxy provisions become operative. We are opposed to this both because it is administratively complex and because any definition of "nearest relative" will have shortcomings in that the person so defined may or may not be the most appropriate person.

We do not wish to recommend any overall policy requiring consent to treatment. We say, however, that when objection is made, subsequent procedures must be undertaken with the greatest of safeguards to ensure that the dignity of the patient is preserved and that the treatment is absolutely necessary.

15.5 Unusual Treatments

There are a number of treatment techniques employed in the psychiatric profession which are controversial both inside and outside the profession. These treatments are controversial because they are often less than completely understood medically, may often be uncomfortable or even painful to the patient, and are often massively intrusive. We do not propose to discuss all such treatments, but hope to make recommendations which would be applicable to the more unusual treatments for legislative purposes.

15.5.1 Electroconvulsive Therapy

It is our understanding that generally excellent results are now being achieved in certain disorders through the use of electroconvulsive therapy. This therapy involves the use of drugs or electric current which when applied to the body create convulsions. The concurrent use of anaesthetics and muscle relaxants have made this a safe and humane procedure.

Although this treatment is to some extent publicly controversial, the therapy has become better defined and established within the profession and the Task Force is satisfied that its use should not be regulated in any fashion different from other treatments.

15.5.2 Psychosurgery

The same cannot be said for psychosurgery. Little or no psychosurgery is being performed in Alberta at this time. There is a large amount of published literature available in this field and a variety of psychosurgery techniques have been employed. The literature and professional opinion is divided as to the effectiveness of many psychosurgery techniques.

In our opinion, until the medical profession can clearly resolve its own doubts about psychosurgery, we believe that it should be approached with very great caution. Psychosurgery should be performed on an involuntary patient only where the most stringent safeguards have been followed. We recommend that there be:

(a) compliance with procedures (i) to (v) as set out above (see 15.4) for performance of treatment generally, contrary to a patient's wishes;

(b) consideration by the review panel of the patient's wishes;

(c) consideration by the review panel of the medical aspects

as well as the implications of the surgery on the overall health of the patient;

and that it be a measure of last resort undertaken when all the "least intrusive" procedures have failed to accomplish the desired result.

15.5.3 Aversive Therapy

The distinction between aversive therapy and abuse is often not apparent. Certainly, the mere characterization of an act as "treatment" does not necessarily make it so. On the other hand, we do not wish the legislation to preclude valid medical treatments merely because they are viewed by the public with some queasiness or mistrust.

This really is a medical question. The acceptability of a given "treatment" is for the profession to determine based upon proper standards.

As a guideline, we would suggest that acts which are humiliating, painful, or abusive on the one hand but offer only minor or insignificant benefits on the other hand, should be discarded. Any such act which offers no medical benefit is not treatment, but abuse, and should be dealt with accordingly.

15.6 Experimental Treatments

The Task Force does not believe that it is ever appropriate to conduct experimental medical treatments upon involuntary patients with or without their consent.

15.7 Compulsory Outpatient Treatment

A concern raised in several submissions involves people who are chronically mentally ill, but who can successfully control their illness if they follow a proper out-patient treatment program. The issue affects discharged patients since treatment in the community can be controlled for short periods of time by granting a leave of absence subject to terms and conditions (see 19.1 and 13.6.2). To quote from the submission of the medical staff of Alberta Hospital Edmonton:

> These people have lapses of insight which lead to their failing to take the treatment that they need; this results in their becoming ill again with consequent social breakdown, often causing great suffering not only to themselves, but also to their relatives and friends.

Because these persons are not dangerousness when taking their medication or in the initial stages of social breakdown, they are not certifiable as involuntary patients and there is, therefore, no legislative authority to compel treatment. The alternatives, then, under current legislation are:

(a) to attempt to persuade the person to take his or her medication; or,

(b) to await serious deterioration in the person's condition until the dangerousness criterion is met, whereupon the person can be committed to a facility and be subjected to compulsory treatment.

The drawback to alternative (b) (there is of course nothing wrong with alternative (a) as long as it works), is that by the time the person's condition has become such as to warrant intervention under the current legislation, he will usually have experienced a great deal of unnecessary suffering. Further, while the problem may initially have been treated by means of minor compulsory treatments, it may have since become so serious as to require very intrusive and lengthy medical procedures.

The criticism directed at the present Act is that there is no "middle ground" which will permit intervention in minor cases requiring minor treatments when such cases are likely, if left untreated, to become major cases requiring major treatments.

The Task Force recognizes the accuracy of the criticism. Unfortunately, we do not believe that there is anything that can be done to solve this problem without removing necessary limitations on the application of the Act.

The most commonly suggested solution to the problem is that upon refusal of treatment by such a person, the person can be committed for treatment in some fashion or the treatment can otherwise be administered by compulsory means – notwithstanding the fact that the person may not at the time be dangerous.

On balance, we view this solution as no better, and possibly worse, than the problem for the following reasons:

(a) The solution is exactly what we hoped would be prevented namely, the return of the person to a facility in what is commonly called the "revolving door syndrome".

(b) The solution can only come about by departing from one of the basic principles of the Act, namely the limitation of its application to persons who, amongst other things, are dangerous. The group involved in this scene (the chronically mentally ill) is a major group. A departure from the principle for this group cannot be regarded as a minor one.

(c) We are concerned that the effect of such legislation would be to relegate these patients to some sort of permanent involuntary status. We do not believe that this would be wise, either therapeutically or socially.

XVI. PATIENT ADVOCACY

16.1 Introduction

The right of a patient to be represented by counsel or by an advocate has long been established.

We are somewhat concerned as to whether or not this goes far enough, however. A number of the submissions, and much recent writing on the topic, have suggested that the state should have an obligation to supply counsel free of charge for involuntary patients or otherwise provide advocacy services to patients who are unable to provide their own.

Currently, there is no such principle at work in Alberta. At best, counsel may be appointed and paid for under the Legal Aid plan, but this is entirely discretionary and the plan is shortfunded. In addition, little expertise has developed within the Alberta Bar to serve the needs of the mentally ill. It appears that the mentally ill of this province have been poorly served insofar as the provision of advocacy services is concerned.

16.2 Rationale For Provision of Patient Advocacy at State Expense

There are a number of reasons why we urge the creation of a patient advocacy system. Amongst these are the following.

16.2.1 The Charter of Rights and Freedoms

The Charter will likely have a major impact on this question. Section 7 of the Charter reads:

> Everyone has the right to life, liberty, and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice.

Section 10(b) reads:

> Everybody has the right on arrest or detention ...
>
> (b) to retain and instruct counsel without delay and to be informed of that right.

These provisions have not been interpreted by our courts at the time of writing this report. Similar principles and concepts are referred to in the American Constitution (for example, the fifth amendment requiring "due process") and American courts have interpreted these concepts as requiring the appointment of counsel, at state expense, for indigent persons under most types of detention.

When we are dealing with a mentally disordered person who is detained without having committed a criminal act, who is often incapable of self-help and who is indigent, it does not require a great leap of reasoning to go from a recognition of

a right to counsel to recognition of a right to counsel paid for by the state.

16.2.2 The Concept of "Fair Treatment"

Totally aside from any constitutional requirement to retain counsel for indigent patients, there is a substantial rationale based upon the essential fairness of the proposition.

Upon admission to a facility and for a considerable period thereafter, an involuntary patient is undergoing a very dramatic alteration to this legal status. This alteration is potentially more radical than any other that we can think of under our law because it involves both detention and treatment against his will.

It usually occurs at a time when the person is intellectually, emotionally, and financially least able to cope. In short, he is incapable of protecting his rights, and unless provision is made for someone else to protect them, there is no assurance that they will be protected.

In such circumstances, the patient is simply incapable of gaining access to the law. Hence, he cannot be said to be equal before the law.

16.2.3 Checking the Power of the Facilities and Staff

We believe that the appointment of counsel in such cases will serve as the necessary check to the power of the facilities.

In circumstances where patients' rights are not actively monitored or exercised, a facility may virtually have a free hand in the treatment of its patients.

It was not the intention of this legislation to provide facilities or their staff with unfettered power to commit persons or provide any treatment that they feel is necessary in the patient's best interest. Nevertheless, such could be the result (regardless of the number of patients' rights proclaimed in legislation) if no one was available to speak on behalf of the patients.

The intention of the legislation is to provide for the involuntary commitment of a limited category of persons and the treatment of such persons without their consent, but only after procedures are followed which are designed to assure that the criteria for commitment are not exceeded, that the treatment is necessary, that the treatment is reasonable, and that the dignity of the patient is preserved. These interests are simply too important to rely solely upon a facility to ensure that they are observed in the face of administrative necessity.

16.3 Other Jurisdictions

Ontario has recently introduced a system of patient advocacy in its hospital system. This system incorporates paid non-lawyer advocates who are employed at each hospital. At this point in time, it is too early to judge the usefulness of this service.

Several American jurisdictions (California, for example) have created elaborate patient advocate systems. These systems are apparently rather expensive, somewhat controversial and, while we have no reason to be critical of these systems in the American context, we do not recommend that they be followed in Canada.

British Columbia has no overall scheme of paid patient advocate services. However, in 1977 an experimental project was commenced whereby free legal services were provided to patients at a Vancouver area mental health facility. The service was established in the form of a small law office located in the facility. The office was staffed by a full-time junior lawyer. A part time senior lawyer did most of the court work and provided guidance to the junior lawyer.

A detailed description of the project is contained in a report entitled "Legal Aid for Mental Patients – An Evaluation Report" by Alexander Himelfarb and Avram Lazar, published by the Department of Justice in April, 1981. Generally speaking, we understand that the experiment is regarded as successful, and in our view it is worthy of emulation.

16.4 Task Force Proposal

We recognize that it is not possible to provide an inexpensive legal advocacy system. However, we submit that given the benefits to be achieved, the necessary expenditure is warranted even in a mental health care system where resources are already stretched to the limit.

It is our recommendation that a legal advocacy service providing free limited legal services for involuntary patients be established under the Mental Health Act. We believe that such should be mandated and required under the legislation. It should minimally have the following features:

(a) In view of the functions of the service, it will have to be staffed by lawyers. We recommend that lawyers be hired on a full-time basis in numbers sufficient to perform the services necessary to protect patients' rights, including regular visits (at least once a week) to all facilities to interview patients who have become subject to newly-issued admission or renewal certificates. This is a departure from the traditional "fee for service" system employed by the Legal Aid System. We see this as an advantage in that (a) it will enable those lawyers who are employed in the system to develop sufficient expertise to be of real assistance, and (b) it will ensure that the service will always be available for patients at least to the extent of the legal staff's ability to handle the caseload. The cost will be known in advance, and it will be possible to budget adequate funds.

(b) The independence of this service must be assured. This could be accomplished by causing the service to report not to a government department directly, but to an independent agency such as the Ombudsman's office or the Provincial Mental Health Advisory Council, or to an outside agency such as the Canadian Mental Health Association, who could operate the service on a grant basis.

(c) The service must be highly visible and accessible to its patients. Sufficient facilities must be provided within the hospitals to enable the service to fulfill its functions.

The scope of individual legal services provided by this service should be limited to matters necessary to ensure that the patients' rights are protected. These services would include:

(a) advising patients individually of their rights upon admission;

(b) acting for patients in all matters pertaining to their release;

(c) acting for patients in all matters pertaining to attempts to provide treatment to patients without their consent;

(d) representing patients in all related procedural matters and in such matters as obtaining access to medical records, etc.; and,

(e) acting for patients in matters pertaining to guardianship and trusteeship, etc.

Because of the anticipated heavy caseload, we do not propose a system which would provide general legal services covering all the legal needs of patients. We would, therefore, preclude the service from acting for patients on personal matters. Lawyers would not represent them, for example, in legal actions having nothing to do with their health, or in actions concerned mainly with recovery of monetary damages such as actions for malpractice against staff.

Some of the advocacy services operating in other jurisdictions provide services of a more general nature, as well as:

(a) educating staff and patients generally of the provisions of all relevant legislation;

(b) reviewing and commenting on proposed legislation; and,

(c) representing the concerns of groups interested in the mental health delivery system.

We view these services as being valuable, but of a lesser priority than the provision of basic legal services. They should, therefore, be a function of the advocacy service only as time permits.

Finally, the Task Force sees a role to be played by non-lawyer advocates. These services would not necessarily be strictly advocate services, but would be best characterized as providing support to patients by:

(a) providing non-legal guidance to patients;

(b) investigating alternatives to hospitalization; and

(c) representing patients in minor "administrative" proceedings, such as loss of privileges, and make initial investigations of minor patient complaints.

We doubt that it is necessary to include the provision of such services in legislation. Most of these services could likely be provided by volunteers. However, as a matter of policy, all hospital boards should be encouraged to permit the introduction of such services.

XVII. PATIENT RECORDS

17.1 Introduction

17.1.1 Terminology

Section 37 of the Mental Health Act covers patient records. It refers to the records of a "person" receiving diagnostic and treatment services. In this chapter we use the word "patient" instead of "person" for convenience of discussion. We do not intend to thereby exclude from the operation of the section a person who is no longer a patient, nor to exclude a person who in any technical sense does not become a patient although he has received services.

We use the phrase "person in charge of the record" or "record-keeper" to mean any person authorized under the Mental Health Act to disclose information on a patient's record.

17.1.2 Importance of Confidentiality

The main purpose of section 37 is to protect the "privacy" or "confidentiality" (we use the words synonymously) of the patient. The court should, therefore, "be vigilant, and demand compelling grounds before permitting access to medical records" by others (*Lindsay*, v. *M.*, 121 D.L.R. (3d) 261 (Alta. C.A.) at 265). A secondary purpose is revealed in section 37(4): to protect the privacy of the patient's attending physician.

The protection of the confidentiality of patient documents lies at the forefront of current public concern. The concern is a response in part to the vast increase in record-keeping and growth in electronic data processing which society is undergoing and which is making information much more accessible. It is a response in part to the current trend to recognize patients' rights, including access by the patient to his own medical records.

The protection of the patient's confidentiality is important because, unfounded as it is, a serious social stigma may attach to a person who is known to have received treatment for mental illness. As one source states ("Developments in the Law, Civil Commitment of the Mentally Ill" (1974), 87 *Harv. L. Rev.* 1193 at 1200):

> ... a former mental patient may suffer from the social opprobrium which attaches to treatment for mental illness and which may have more severe consequences than do the formally imposed disabilities. Many people have an "irrational fear of the mentally ill". The former mental patient is likely to be treated with distrust and even loathing; he may be socially ostracized and victimized by employment and educational discrimination. Finally, the

individual's hospitalization and posthospitalization experience may cause him to lose self-confidence and self-esteem.

Some diagnostic terms have discriminatory social connotations and may cause injury if made known to others. Insurance coverage or benefits may be lost. Some persons may avoid necessary psychiatric treatment out of fear of disclosure.

The protection of confidential information from disclosure is also necessary to encourage those who require professional help to participate in treatment and to be totally candid. Fear of disclosure is detrimental to the therapeutic relationship.

17.1.3 Physician's Duty of Confidentiality at Common Law

The common law affords protection against the unauthorized disclosure or use of information which is of a confidential nature and which has been entrusted to a person in circumstances which impose an obligation to respect its confidentiality. The obligation of a physician is implied from his professional relationship with his patient.

Persons employed by the physician or acting under his supervision must, as his agents, observe the same duty of confidentiality.

It is likely that the common law imposes an analogous duty of confidentiality on members of other health care professions who are in a direct relationship with patients. However, the case law on the point is sparse.

The ethical code of the medical profession also contains an obligation of confidentiality and a physician may be disciplined for breaching the obligation. Other professions may maintain similar standards of professional conduct.

In some circumstances disclosure to a third person by the person holding the confidence will be neither unethical nor illegal. For example, the public interest might well justify a physician in notifying the employer that his patient, an air traffic controller, is under severe marital stress and potentially suicidal. The physician has a discretion to disclose without being sanctioned legally or ethically. He is not obliged to disclose. Disclosures, in the patient's interest, to other persons involved in his care and treatment may also be justifiable.

The disclosure of otherwise confidential health care information may be compelled in court proceedings.

17.1.4 Confidentiality of Patient Records Distinguished

The records of a board-operated hospital or a government-run mental health clinic or other treatment service are maintained by and accessible to many persons — some medical, some non-medical; some professional, some non-professional. Ultimate responsibility for the provision of care and treatment does

not lie with an individual physician but with an institutional board or other management unit. The issues pertaining to confidentiality are more complex than those raised by the traditional one-toone physician and patient relationship from which the duty of confidentiality was developed at common law. Many jurisdictions, including Alberta, have therefore resorted to legislation to establish clearer guidelines.

17.2 Charter Implications

A constitutional right to privacy has been recognized by the United States Supreme Court in recent years (*Griswold v. Connecticut,* 381 U.S., 479; *Roe* v. *Wade,* 410 U.S. 113). The right is derived from a construction of several provisions in the U.S. Constitution which have counterparts in the Canadian Charter (e.g. right to freedom of thought, section 2; right to life, liberty and security of the person, section 7; right not to suffer any cruel and unusual punishment, section 12; preservation of existing rights, section 26).

The American Bar Association has asserted that "in the physician-patient relationship, privacy has 'no more conspicuous place' than in treatment for mental and emotional conditions" (Mental Disability Law Reporter, September-December 1977, 339). The statement amplifies the words of Mr. Justice Douglas in *Doe* v. *Bolton* (1973), 410 U.S. 179 at 219, that "[t]he right of privacy has no more conspicuous place than in the physician-patient relationship".

Canadian courts are very likely to find a right to privacy similarly couched in the words of our Charter.

17.3 Scope of Records Provisions

17.3.1 Facilities and Services

Section 37(1) defines "diagnostic and treatment centre" or "centre" to mean any place established by the Minister under section 3(1). Section 3(1), in turn, authorizes the Minister to establish and operate places "for the observation, examination, care, treatment, control and detention of persons suffering from mental disorder." The definition appears to include facilities designated under the Act and mental health clinics operated by the government in each of the six social service regions.

The Task Force agrees that the records provisions in the Mental Health Act should apply to the records maintained in all facilities (DF1, DF2 and DF3) designated under the Mental Health Act and in any other mental health service established by the Minister.

17.3.2 Patients

Section 37 applies to the records kept in respect of a person who has received services in a diagnostic and treatment centre. Its application is not confined to involuntary patients.

The Task Force agrees that the confidentiality of the records of both voluntary and involuntary psychiatric patients should be protected, as now.

We note that section 40 of the Hospitals Act, R.S.A. 1980, c.H-11, is substantially the same in content as section 37 of the Mental Health Act although there are some differences in detail. The patients whose records are protected by section 40 will be voluntary. Some of them may be psychiatric patients hospitalized in wards which have not been designated as facilities under the Mental Health Act.

Our recommendations are developed around section 37 of the Mental Health Act. We recommend that the government consider making comparable amendments to section 40 of the Hospitals Act to protect voluntary psychiatric patients who are not hospitalized in designated facilities.

Section 37 of the Mental Health Act should prevail for the records of voluntary patients being cared for in designated facilities which, in other respects, are subject to the Hospitals Act or other legislation.

17.3.3 Meaning of "Record"

Section 37(2) of the Mental Health Act obliges the Minister to "cause a record to be kept of the diagnostic and treatment services provided to every person in a diagnostic and treatment centre." Section 37(2.1) likewise obliges the Board of a mental health hospital to "cause a record to be kept of the diagnostic and treatment services provided to every person in the mental hospital hospital". By sections 37(1)(c) and 48(b), "a mental health hospital" is defined as "a hospital administered by a Board for the care or treatment of persons suffering from a mental disorder". Section 49 establishes the Mental Health Hospital Board, Ponoka and the Mental Health Hospital Board, Edmonton to administer the two Alberta Hospitals.

Section 37(3) restricts the release of:

(a) medical and other records in a centre;

(b) extracts from and copies of those records;

(c) diagnoses, charts or information available in respect of any person receiving diagnostic and treatment services in a centre.

Thereafter, subsections (6) to (11) use the words "diagnosis, record or information".

"Record" is not defined. The Canadian Council on Hospital Accreditation (January 1983) at 80-81, requires the record to contain: patient identification data; the admitting diagnosis; a history of patient; a report of the physical examination; consent forms; diagnostic and therapeutic orders; progress notes, reports and consultations; and a discharge summary.

In the case of *Lindsay* v. *M.*, Mr. Justice Kerans comments (at 266):

> Parenthetically, I understand that a hospital chart is a fairly formal record of the stay of a patient, including reports from many sources, and apparently accessible to all the professional staff. It is not in any way a personal or private note in the manner of the first draft of this judgment or the personal file of a physician, for example.

The Task Force does not recommend that "record" should be defined in the Act. The only effect of defining the record would be to possibly exclude some documents not covered by the definition. Nor do we make recommendations about what should be contained in the record. We do emphasize, however, that the complete record should be protected from disclosure except as permitted by the Act.

17.4 Prohibition of Disclosure

17.4.1 General Rule of Nondisclosure

A general rule of nondisclosure is inherent in section 37. Subsection (4) specifically prohibits the disclosure of information except for use for a public purpose authorized by the Minister. In the event of release, subsection (4) directs that the information "shall not be published, released or disclosed in any manner that would be detrimental to the personal interest, reputation or privacy of that person or that person's attending physician".

The Task Force agrees that a general rule of nondisclosure is the correct initial stance from which to protect the confidentiality of patient records.

17.4.2 Exceptions

Subsections (3), (6), (7) and (9) of section 37 contain exceptions to the general rule of nondisclosure.

We discuss the disclosures which should be permitted, making reference to these subsections, under the following headings; access by the patient (17.5); disclosure with the patient's consent or in his best interests (17.6); disclosure for a public purpose (17.7); limitations on extent of disclosure (17.8); and court application for order to disclose (17.9).

17.5 Disclosure to Patient

17.5.1 Position at Common Law

The common law on access by the patient to his records is hazy. The records belong to the hospital or physician preparing them. To gain access "the patient would have to make out some property interest or contractual right" (*Lindsay* v. *M.* at 265).

17.5.2 Position Under the Mental Health Act (section 37(6)(a))

Subsection (6) of section 37 lists thirteen categories of persons or agencies to whom disclosure may be made. The disclosure is not automatic but permissible in the discretion of "the Minister, a person authorized by the Minister, a Board or employee of the Board or a physician". Some of the disclosures authorized are in the patient's best interests (see 17.6); others are for a public purpose (see 17.7).

Paragraph (a) authorizes disclosure to the patient. He is first on the list. This is appropriate because access by the patient to his own records does not interfere with the primary purpose of the section which is to protect the patient's right of privacy. The patient has "a special right of access" (*Lindsay* v. *M.* at 267).

17.5.3 Policy Considerations

Two contrary views on access by the patient to his own medical records are discussed in the case of *Lindsay* v. *M.* One is that the physician must be trusted to tell the patient what he needs to know. The other is that the patient "... has something akin to a proprietary interest in the contents of these records.." (*Re Mitchell* and *St. Michaels Hospital* (1980), 112 D.L.R. (3d) 360 at 364 (Ont. H.C. *per* Maloney J.).

Arguments Against Patient Access

The proponents of the view that the physician must be trusted to tell the patient what he needs to know argue:

(1) An unrestricted right of access by the patient to his own health records is not in his best medical interests. He might, or would likely, misunderstand terms. Knowledge of the information on the record may be upsetting to him, and could even endanger his life.

(2) Psychiatric records frequently contain confidential information about or from a third person. Access by the patient is likely to adversely affect the future candour of third persons in communication with health care staff because of the fear that the disclosure of the information to the patient would put them at risk of harm.

(3) Access by the patient is also likely to adversely affect the

candid recording of opinions by health care professionals. The fear that disclosure to the patient would put them at risk of harm or expose them to lawsuits brought by the patient may intimidate health care professionals into keeping incomplete records. A system of private record-keeping may even start up. These changes would lead to harm to the practice of medicine generally.

Rebuttal to Arguments Against Patient Access

The view that only mischief would result from any rule other than that the doctor must be trusted to tell the patient what he needs to know was challenged rhetorically by Mr. Justice Krever in the Report of "The Commission of Inquiry into the Confidentiality of Health Information" (Ontario, Queens Printer, 1980, p. 10, hereinafter "the Krever Commission", quoted in *Lindsay* v. *M.* at 266).

> Knowledge is power. Knowledge about another person, knowledge, that is, that the person does not have, is, surely, power over that person. Does the therapeutic relationship truly require that a physician have power over his or her patient?.. and how can depriving a patient of the opportunity of reviewing his or her record be reconciled with respect for the dignity of every adult and mentally competent member of the community that our society wants to be respected?

The contrary arguments follow:

(1) In refuting the argument that access may be against the medical interests of the patient, Mr. Justice Kerans says (*Lindsay* v. *M.* at 267):

> ... I strongly suspect that the applicant, were he to read the file, would be upset, particularly if much of it is not explained to him by somebody with some training. But this alone is hardly grounds to suggest that it is against his medical interest for him to read it. After all, he is equally likely to be upset if he is not permitted to read it.
>
> Moreover, disclosure may be positively therapeutic. Studies have found that, far from being detrimental, access may allay suspicion, contribute to the forming of trust relationships between staff and patients, and lead to a higher ratio of consents to treatment. Notably, only a small percentage of patients request access to their records when it is opened up.
>
> A right of access can serve as a therapeutic tool because a great deal of the psychotherapeutic work consists of helping the patient to see how others see him. In addition paranoid persons, in general, are made more paranoid if

they do not have access to everything they consider important.

(2) The risk of the impairment of the future candour of lay persons in communication with a physician by reason of the disclosure of the records to the patient is unverified. The point was argued on behalf of the facility in *Lindsay* v. *M.* (at 268) but no evidence was led to substantiate it. We propose to deal with it by permitting the record-keeper, where he perceives potential risk to a third person from disclosure, to apply to the review panel for permission to withhold the offending portion of the record from the patient (see 17.5.5).

(3) No reputable health care professional would omit relevant information from the record because of a right of access. As Mr. Justice Kerans stated (*Lindsay* v *M.* at 268):

> In my view it is unthinkable that the healing professions require a prior and blank assurance of confidentiality, without which they would fail in their professional duty.

What is more, studies conducted at the St. Elizabeth Psychiatric Hospital in Washington, D.C. and the Riverview Psychiatric Hospital in British Columbia showed that the possibility of disclosure to the patient led to more accurate recordkeeping with less use of jargon.

Arguments in Favour of Patient Access

In addition to the notion that the patient has a kind of proprietary interest in records maintained about him, three points may be made.

(1) The principles of fundamental justice guaranteed by section 7 of the Charter may require access by an involuntary patient since he is entitled to know the case for detention in order to exercise his right to challenge it.

(2) Access to the records will assist a voluntary patient to make informed decisions about treatment, and an involuntary patient to decide whether or not to object to treatment.

(3) Access is necessary to allow a patient to make informed decisions about the release of health information to a third person.

17.5.4 Patient Access As Of Right

The patient should continue to have "a special right of access". The Task Force recommends that:

(1) every person should generally be entitled to see all records which are kept about him;

(2) the entitlement should not be limited to the occasion of review panel hearings; and

(3) the entitlement should be by right and not, as now, in the discretion of persons in charge of the record or, if that authorization cannot be obtained, on order of the court (see 17.10).

These recommendations are subject only to an order by the review panel permitting the withholding of a part of the record where disclosure would jeopardize the confidence or security of a third person (see 17.5.5).

The right of access of the patient should be to see the original record, but not to take it away. The patient could have a copy of it. Administrative protections may be necessary to avoid or prevent any defacing or other alteration of the record by the patient.

17.5.5 Exception for Security or Confidence of a Third Person

Application to Withhold a Portion of the Record

We have recommended that the patient should enjoy a general right of access to his record. We believe, however, that a residual power to consider whether any portion of the record needs to be withheld from him should lie with the review panel. The power should be exercisable only in carefully defined, highly exceptional circumstances. It should be triggered by the application of a person in charge of the record. The patient should be notified of the fact that an application is being made. He is entitled to be represented at the hearing but not, of course, to disclosure of the information which is the subject matter of the application. No cost to the patient should be occasioned by the review.

Time for Bringing Application

The person in charge of the record should have no more than 14 days from the date of the patient's request for access within which to bring the application. Where no application is commenced within this time, the patient should be entitled to disclosure of the entire record.

Reasons for Application

Risk of Harm to a Third Person. The recordkeeper may perceive that the release of information on the record to the patient would place a third person in danger. For example, a paranoid patient may wish to seek revenge against a person whom the record discloses provided information leading to the certification.

We recommend that the recordkeeper should be able to raise his doubts with the review panel by bringing an application for an order permitting him to withhold the sensitive information.

Equitable Doctrine of Confidentiality. The equitable doctrine of confidentiality protects a person who has made a communication in confidence from misuse of the information. Where the doctrine applies the court will make an order to prohibit the person to whom the communication was made from making a wrongful disclosure. If the information given in confidence has already been disclosed, the court may award damages against the person who has breached his duty to maintain the confidence.

In the case of *Lindsay* v. *M.*, notwithstanding that the interests of the patient were held to be the primary concern under section 37, the Alberta Court of Appeal stayed the order for the release of the record to the patient for sixty days. The purpose of the delay of the release was to allow the patient's wife to be notified of the impending disclosure of a letter from her so that, should she choose to do so, she could bring proceedings for an injunction to restrain the disclosure.

The fact that information on the record has been received in confidence from a third person should be taken into account. Here, too, we would give the person in charge of the record an opportunity to apply to the review panel for an order permitting him to withhold the information from the patient.

The person who provided the confidential information should be notified of the patient's request for access to it, of the application for an order to withhold, and that he is entitled to be heard on the application.

The application should not be heard until at least 14 days from the date of the patient's request for access, to permit time for notification to the provider of the information. If he has no objection to the disclosure, he should say so promptly in writing (a form could be provided) and the application should be dropped. If he does object, the delay will give him time to seek an injunction from the Court of Queen's Bench to prohibit the disclosure, or to prepare argument for the review panel.

The person in charge of the record may be unable to locate the person who communicated the confidential information. If the review panel is satisfied with the attempts which have been made to find and notify him, it should be empowered to dispense with the requirement of notice and go ahead with the hearing. If the review panel is not satisfied, it should direct what further steps must be taken before the hearing of the merits of the objection proceeds in his absence.

Risk of Harm to Patient Not a Factor. We understand that in most cases it is not harmful to the patient to see his record. The disadvantages of disclosure in the few cases where it would be harmful do not outweigh the advantages of making records generally available to patients. We would, therefore, not permit withholding from the patient on the basis that disclosure would constitute a danger to the patient himself.

Section 47(1)(c) of the Mental Health Act, which pertains to the making of regulations, infers that the review panel may withhold documentation from the patient. It should be amended to remove this inference.

Test for Withholding

In deciding whether to make an order to withhold a portion of the record from the patient, the review panel should weigh the patient's interest in and need for disclosure (for example, whether it is necessary to enable him properly to contest the detention or effectively to object to his treatment or to achieve some other purpose) against the risk of harm by disclosure to the security or confidence of a third person, the future candour of third persons supplying information or of health care personnel recording information, and the delivery of mental health care services in general.

Onus of Proof

The onus of demonstrating the compelling reasons why any portion of the record should not be disclosed to the patient should fall on the person seeking the order to withhold. This is where the onus lies under section 37(11) when application is made to the court for an order directing disclosure to the patient (see 17.10).

Appeal from Decision of Review Panel

Both the patient and the person in charge of the record should have the right to appeal the decision of the review panel to a single judge of the Court of Queen's Bench. There should be no further appeal.

17.6 Disclosure With Patient's Consent Or In His Best Interests

17.6.1 Introduction

There are many occasions when disclosure to third persons could be in the patient's best interests. These include disclosure: to his legal counsel; to the person named by him as his representative or any other person, perhaps a friend or family member, who is willing to assist him; to the Ombudsman; to a present or prospective employer; to a physician being consulted for an independent opinion; to a government or other agency for assistance or benefits; to a community agency offering a program for which the patient may be eligible; to persons involved in subsequent treatment; and to an insurance company for coverage or benefits.

17.6.2 Disclosure with Patient's Consent (section 37(6)(b))

Section 37(6)(b) permits disclosure to be made with the written consent of the patient "if in the opinion of the person making the disclosure it is in the best interests" of the patient. As we have said (17.5.2), the person making the disclosure may be

"the Minister, a person authorized by the Minister, a Board or an employee of the Board or a physician".

Where Patient Competent to Consent

The Task Force believes that the primary determinant of the flow of mental health information to persons outside the treatment context should be the informed, voluntary consent of the patient.

Subject to the exception discussed under the next heading, the disclosure should be as of right where the patient has the requisite mental competence to give a valid consent to the release of information. The opinion of the person in charge of the record about what is in the best interests of the patient, should not be a factor. It should be for the patient to decide what is in his own best interests.

Section 37(6)(b) should be amended accordingly.

Exception for Security or Confidence of Third Persons

The right of a competent patient to direct the disclosure of his medical record should be subject only to the right of the person in charge of the record to apply to the review panel for an order to withhold a portion of the record on the same compelling basis as access may be withheld from the patient himself (i.e. information received in confidence from a third person and risk to third persons from its revelation to the patient).

17.6.3 Disclosure Without Patient's Consent

Where Patient Incompetent to Consent (section 37(6)(b))

The mental condition of a patient may render him incompetent to give a legally valid consent to disclosure. We believe that it should be possible for persons in charge of the record to make disclosures where the patient lacks the requisite competence to give his own consent. To this end, we recommend that the reference to the written consent of the patient be deleted from section 37(6)(b) and that the remainder of the paragraph be retained so as to permit disclosure where the person in charge of the record is of the opinion that the disclosure is in the best interests of the patient.

Disclosures Authorized Under the Mental Health Act

Paragraphs (c) to (m) of section 37(6) authorize disclosures to be made without the patient's consent. The disclosures under paragraphs (c), (d), (e), (f), (i) and (l) are in the patient's best interest. The other disclosures are for a public purpose (see 17.7).

As for paragraphs (a) and (b), the disclosure is in the discretion of "the Minister, a person authorized by the Minister, a Board or an employee of the Board or a physician".

We considered whether the consent of a competent patient should be required before disclosures may be made under paragraphs (c), (d), (e), (f), (i) and (l). However, we concluded that disclosure is sufficiently important in these situations to prevail over any requirement of consent by the patient. The higher social interest in disclosure outweighs considerations of patient consent.

Disclosure to Facilitate Treatment (section 37(6)(c)).

Section 37(6)(c) authorizes disclosure of the record to a department or agency of the Government or a physician responsible for providing continued treatment to the patient.

The Task Force has recommended (see 10.4) that the continuity of treatment of an involuntary patient should not be broken. His record should follow him through detention. The board of the facility from which he is being transferred should have a duty to forward his medical record to the facility to which he is going without delay. It should not be a discretionary matter.

We also see a strong case for encouraging the flow of patient information to persons providing continued treatment in the community. We read section 37(6)(c) to facilitate the discretionary disclosure of the record for this purpose. This being so, we find section 37(6)(c) satisfactory in other respects.

Disclosure to the Public Guardian (section 37(6)(d)). Section 37(6)(d) authorizes the disclosure of the record to the Public Guardian where it is relevant to the making of a guardianship order or a trusteeship order under the Dependent Adults Act. We recommend the continuation of this provision.

Disclosure to Review Panel (section 37(6)(e)). Section 37(6)(e) authorizes disclosure of the record to a review panel hearing an application by the patient. Again, the disclosure is in the discretion of the persons or authorities referred to in the opening lines of section 37(6).

The Task Force thinks that the review panel should have an unrestricted right of access to the records of a patient with respect to whom an application for review has been made. The disclosure of the record to a review panel should be compulsory, not discretionary.

Disclosure to a Department or Agency of Government (section 37(b)(f)). Section 37(6)(f) permits the disclosure of the record to a department or agency of the Government when the disclosure is necessary in the administration of the Mental Health Act or in the best interests of the patient.

This provision is redundant insofar as it pertains to disclosure in the best interests of the patient in light of our recommendations for the amendment of section 37(6)(b) (see 17.6.2 and 17.6.3). Disclosure necessary in the administration of the Mental Health Act is a public purpose disclosure (see 17.7).

Disclosure to Establish Liability for Payment (section 37 (6)(i)). Section 37(6)(i) authorizes disclosure to a Workers' Compensation Board, the Alberta Hospital Association or a provincial hospital insurance authority to establish its liability for payment. We read this to mean payment to or on behalf of the patient. The provision should be continued.

Disclosure to Board of Review (section 37(6)(1)). Section 37(6)(l) authorizes disclosure to a board of review appointed under the Criminal Code (Canada) that is to review the patient's case.

The situation is analogous to the review of a patient's detention by a review panel appointed under the Mental Health Act (See Disclosure to Review Panel (section 37(6)(e)). We recommend that the right of access of the board of review likewise should be automatic and unrestricted.

17.6.4 Application for Directions

Where the person in charge of the record is in doubt about whether the record should be disclosed, he should be entitled to apply to the review panel for an order of directions. The legal advocacy service should be notified of the application.

17.7 Disclosure For A Public Purpose

The Task Force believes that at times the public interest and need for disclosure will outweigh the risk of injury to the patient, to the physician and patient relationship and to the treatment services which may result from the disclosure. In these circumstances disclosure should be possible without the consent of the patient.

Examples of purposes for which disclosure may legitimately be made in the public interest include research, education, government administration (accreditation, statistics), law enforcement and security, and the administration of justice (court proceedings).

17.7.1 Disclosures Authorized Under the Mental Health Act

Disclosure for a public purpose is authorized by section 37 of the Mental Health Act in subsections (3), (6), (7) and (8). The reader is reminded that disclosures under subsection (6) are in the discretion of "the Minister, a person authorized by the Minister, a Board or an employee of the Board or a physician".

Disclosure for a Purpose Considered by the Minister to be in the Public Interest (section 37(3))

Subsection (3) allows disclosure "[f]or the purposes of assessing the standards of care furnished to persons in a diagnostic and treatment centre, improving mental health care facilities or procedures or for any other purpose considered by the Minister to be in the public interest". Where these circumstances exist, "the Minister or any other person authorized by the Min-

ister" may require the record to be sent "to the Minister or any person designated by the Minister".

The Task Force recommends the continuation of this provision.

Disclosure Necessary in the Administration of the Mental Health Act (section 37(6)(f))

Section 37(6)(f) permits the disclosure of the record to a department or agency of the Government when it is necessary in the administration of the Act.

We recommend its continuance.

Disclosure for Bona Fide Research or Medical Review (section 37(6)(g))

Section 37(6)(g) authorizes disclosure to a person conducting bona fide research or medical review. The disclosure must be made in such a manner as to ensure the patient's confidentiality.

This provision should be continued.

Disclosure of Information Relating to an Occupational Accident or Disease (section 37(6)(h))

Section 37(6)(h) authorizes disclosure to the Director of Medical Services under the *Occupational Health and Safety Act* when the information relates "to an accident that occurred in respect of the [patient's] occupation or one or more of his former occupations, or to a disease which is related to the [patient's] occupation or one or more of his former occupations".

We recommend that paragraph (h) be continued.

Disclosure to the Department of National Health and Welfare (section 37(6)(j))

We understand that the purpose of section 37(6)(j) was to administratively facilitate various provisions of the Medical Care Act (Canada) and the Hospital Insurance and Diagnostic Services Act (Canada), both of which Acts contain provision for reimbursement of the provincial government by the Government of Canada for the cost of certain health care services initially paid for by the Government of Alberta. The arrangements require disclosure of health care information under certain circumstances as a precondition to receiving the reimbursement.

It has occurred to us that it may not be necessary to provide all of the information contemplated in section 37 to the Department of National Health and Welfare in order to satisfy the requirements of either Act. We understand that the exact nature of the information to be disclosed, together with guarantees as to the maintenance of confidentiality of the information by the Government of Canada, are contained in an agreement

between the Government of Canada and the Government of Alberta. We understand that this agreement has been satisfactory and, in our brief investigation of its operation, we were not advised of any alleged abuses of the confidentiality provisions on the part of the Government of Canada.

It is hoped that the proposed new Canada Health Act may contain cost sharing provisions for mental health care. These will likely require disclosure of mental health information to the Government of Canada. Further comment with respect to section 37(6)(j) should therefore await the passage of the new Canada Health Act.

In summary, we recommend that section 37(6)(j) of the Mental Health Act be retained, but reviewed again when the provisions of the new Canada Health Act are finalized.

Disclosure to a Medical Records School (section 37(6)(k))

Section 37(6)(k) authorizes disclosure to a medical records school for training purposes. The disclosure must be made "in such a manner that individual names of the person to whom the records relate are not revealed or made identifiable".

It should be retained.

Disclosure to the College of Physicians and Surgeons (section 37(6)(m))

Section 37(6)(m) authorizes disclosure to the Alberta College of Physicians and Surgeons or an investigating committee under the *Medical Profession Act,* if

(i) an officer of the College makes a written request for the diagnosis, record or information and the disclosure is consented to by the person to whom the diagnosis, record or information relates or his legal representative, or

(ii) the disclosure is made in compliance with a notice under section 49 of the *Medical Profession Act,* to attend as a witness or to produce documents.

Section 49 of the Medical Profession Act empowers the registrar of the College to issue a notice to enforce the attendance of a witness and the production of books, papers and other documents before a committee investigating the conduct or capability or fitness of a registered medical practitioner to practise.

Section 27(6)(m) should be retained. (With regard to disclosure to other professional bodies for disciplinary purposes, see 17.7.2.)

Disclosure for Purposes of the Fatality Inquiries Act (section 37(7) and (8))

Subsection (7) entitles a medical examiner appointed under the *Fatality Inquiries Act* to inspect and make copies of the record of a patient. Subsection (8) permits the provincial judge presiding at a public inquiry under that Act to admit the copy in

evidence, but requires all proceedings related to it to be in private.

These two subsections should be preserved.

17.7.2 Other Disclosures

Disclosure to Professional Bodies for Disciplinary Purposes

We have recommended the continuation of section 37(6)(m) which authorizes disclosure to the Alberta College of Physicians and Surgeons for the purpose of investigating the conduct or capability or fitness of one of its registered members to practise medicine (see 17.7.1). Other professional groups have submitted that they should have access to patient records for the same purpose.

The Task Force thinks that the dissemination of records without the consent of the patient should be limited to exceptional cases. We would not, therefore, extend the exception under subparagraph (ii) of section 37(6)(m) to other professional bodies. Any records would, of course, be accessible with the consent of the patient as subparagraph (i) allows or, if the patient cannot consent, where one of the persons having discretion to release sees disclosure as being in the patient's best interests.

Disclosure for Law Enforcement or Public Safety

A physician may breach his common law duty of confidence to his patient, in good conscience and with justification, when the protection of the public outweighs his duty to maintain secrecy. Revelation of the information to the police is justified where a serious crime such as murder, rape, robbery, hijacking, hostage-taking or kidnapping is about to be or has been committed. It is also justified, under statute, for the protection of children who have been mistreated, or for the protection of the public from a person who is unfit to drive by reason of illness or alcohol or drug abuse (Ellen I. Picard, *Legal Liability of Doctors and Hospitals in Canada* (Toronto: Carswell's, 1978), 39-40).

Where, as under the Mental Health Act, the confidentiality of patient records is protected by statute the question of disclosure is no longer one for the physician to make in accordance with his conscience. The physician must comply with the requirements of the Act. The Mental Health Act does not specifically authorize disclosure in the interests of public safety or law enforcement. Disclosure for this purpose could only be made with the consent of the Minister, under section 37(3), where he considers it to be in the public interest.

The Krever Commission of Ontario, in chapter 16, made recommendations for legislation which the Task Force thinks would be useful.

Disclosure to Police. Recommendation 21 (Krever Report, c. 16) opposes the enactment of legislation that would require hospitals or health-care facilities, the employees, physicians or other health-care workers to report to the police gunshot wounds, stab wounds or any other injuries indicating the commission of a crime or a statement by a patient of any intention to commit a crime. We would not require such reporting either.

Recommendation 24 (Krever Report, c. 16) is that when a senior official of a hospital or health-care facility or a physician believes, on reasonable grounds, that a patient has been a victim or the perpetrator of a crime, he or she may so inform the police without the patient's authorization.

The Task Force adopts this recommendation but wants the decision to inform the police to be made by a Deputy Minister in each individual case rather than by a "senior official".

Disclosure to Prevent Danger to Patient or Third Persons. Recommendation 23 (Krever Report, c. 16) is that legislation be enacted to provide that, when a senior official of a hospital or health-care facility has reasonable cause to believe that a patient is in such mental or emotional condition as to be dangerous to himself or the person of another or others and that disclosure of information about the condition of the patient is necessary to prevent threatened danger, he or she, specially designated by the board of the hospital or health-care facility for the purpose, may disclose that information without the consent of the patient.

We recommend the enactment of a similar discretion to disclose information under the Mental Health Act.

Disclosure for the Protection of Children. An important instance of disclosure to prevent danger to a third person is disclosure for the purpose of protecting a child. In its recent Report, the Cavanagh Commission (*Board of Review: The Child Welfare System,* October 1983, at 192) recommends that section 37 of the Mental Health Act be amended "to permit disclosure to the Director of Child Welfare of information about a person who has or proposes to have the care and custody of a child or in any other case likely involving the safety of a child".

The Child Welfare Act introduced in the Legislature 16 November 1983 as Bill 105 also proposes an amendment to section 37. If enacted, section 94 would amend section 37(6) of the Mental Health Act by adding the following subsection:

> (6.1) Notwithstanding subsection (4) or any other law, if the Provincial Court issues a subpoena pursuant to the *Child Welfare* Act, a Board, an employee of the Board, a physician, the Minister or a person authorized by the Minister shall release, in accordance with that Act, any diagnosis, record or information in respect of the child to whom the proceedings before

the Provincial Court relate or with respect to a guardian of that child.

We share the concern for the safety of children. Where there are grounds to suspect that a child is in danger, our recommendation immediately above, permitting disclosure to prevent danger to a third person, would give a basis for release of the record. Where wardship proceedings are in progress, our recommendation immediately below for legislative recognition of the common law exception authorizing disclosure in court proceedings would enable a court to compel the release of the mental health record.

The amendment proposed in Bill 105 is specific to a subpoena issued in the Provincial Court pursuant to the *Child Welfare Act*. It is also limited to the record of the child or his guardian. It is consonant with our principles as far as it goes, although we wonder if it should not extend as well to the record of a person likely to be in close association with a child.

We do not favour the granting of any right to the Director of Child Welfare to automatically review the mental health records of anybody, including those records of prospective guardians. The Department could and should require those persons applying to become foster parents to consent to the disclosure of their mental health records as a condition of the application.

Disclosure in a Court of Law

Communications made by a patient to his physician in confidence are not protected or "privileged" from disclosure in a court of law. A physician cannot refuse to reveal, in court, a confidence that is relevant to the proceedings and has probative value. A judge may, on occasion, refrain from compelling him to make the disclosure.

Disclosure in a court of law is required in the interests of the fair administration of justice and the ascertainment of truth in the proceedings before the court. These interests override the private interests of the person who communicated the information.

Section 37 of the Mental Health Act does not stipulate that disclosure in a court of law forms an exception to the general principle of non-disclosure. We recommend that the current law requiring disclosure in court be continued and that this should be legislated to dispel any doubt.

Where confidential information is disclosed in any court proceeding, we would empower the court to make an order banning the publication of the names or other identifying information the publication of which may be detrimental to the personal interest, reputation or privacy of any person participating in the proceedings.

Disclosure Under Statute

Statutes other than the Mental Health Act contain provisions requiring physicians to divulge information obtained from patients for "the protection of public health, the assessment of standards of health care, the improvement of procedures, the fostering of research and teaching, the obtaining of vital data such as deaths and births, the protection of children and the compensation of workers" (Picard, at 35). Similarly, another statute may encourage reporting by purporting to protect the physician from liability for doing so (e.g. Motor Vehicle Administration Act, R.S.A. 1980, c. M-22, s. 14(2) and (3), with regard to a person whom the physician considers unfit to drive).

In some jurisdictions, "disclosures authorized by law" are included in the legislated exceptions to the confidentiality of patient records. A statutory provision requiring disclosure may thereby take precedence over the general prohibition on the disclosure of mental health records. Should the situation arise, we would prefer to see the merits of disclosure or nondisclosure weighed in light of the interests at stake under the two competing statutory provisions. We, therefore, do not recommended any change to the Mental Health Act.

17.8 Form of Authorization of Disclosure

17.8.1 Consent of Patient

Section 37(6)(b) requires the consent of the patient to be in writing. It does not say more about its form.

The Task Force believes that a blanket consent to disclose information on the record is insufficient. We agree with the Krever Commission that for the consent of the patient to be informed, he should know precisely what information is being released, the possible consequences of disclosure, and that he may refuse to sign the consent or later rescind or amend it.

We agree that the patient's consent should be in writing and recommend that a form be specified (see 17.8.3).

17.8.2 Authorization by Another Person

Whenever confidential information is disclosed by a person other than the patient we believe that the authorization for the disclosure should likewise be in writing. The statement of authorization should show the authority for the disclosure, the persons or agencies to whom the disclosure is made and the purpose for which the information is disclosed. A form of authorization should be provided (see 17.8.3).

17.8.3 Form

We recommend that forms be devised for the release of information pursuant to the consent of the patient or the authorization of another person. The forms should be similar in content.

Our recommendations are based on those of the Krever Commission, derived in turn from the legislative scheme outlined in U.S. Federal Privacy of Medical Information Act, H.R. 5935, and proposed to us for adoption by the Calgary Civil Liberties Association. The form should:

(1) state the position of the person authorizing the disclosure (patient or another), be signed by him, witnessed and dated;

(2) give a date or event upon which the consent expires;

(3) name or otherwise describe the health care facility or service in possession of the record;

(4) name the recipient to whom the information is to be released;

(5) describe the extent and nature of the information to be disclosed;

(6) describe the purpose for which the information is to be disclosed; and

(7) state the authority for the disclosure.

17.9 Limitations on Extent of Disclosure

17.9.1 Restriction on Use of Information (section 37(4))

Section 37(4) of the Mental Health Act requires information obtained from patient records to be "treated as private and confidential", to be "used solely for the purposes described in subsection (3)", and "not to be published, released or disclosed in any manner that would be detrimental to the personal interest, reputation or privacy of [the patient or his] attending physician". Subsection (3) is the general public purpose disclosure provision. It permits release "[f]or the purposes of assessing standards of care furnished to persons in a diagnostic and treatment centre, improving mental health care facilities or procedures or for any other purpose considered by the Minister to be in the public interest" (see 17.7.1).

Section 37(4) does not restrict the information which may be disclosed. Nor does it expressly curtail the use which may be made of information disclosed under the authority of later subsections. (Section 37(5) does, however, make unauthorized disclosure an offence: see 17.12.)

We believe that disclosure should be of as little information as is needed to meet the purpose of the disclosure, and recommend the incorporation of this principle in legislation.

We further recommend that section 37(4) should be redrafted to apply to all information obtained from patient records, and not just that disclosed for a public purpose under subsection

(3). It should, as now, require the information disclosed to be treated as private and confidential, used solely for the purpose for which it is released, and not to be published, released or disclosed in any manner that would be detrimental to the personal interest, reputation or privacy of the patient.

(See 17.12 for sanctions of wrongful disclosure.)

17.9.2 Protection of Personal Identity

As a general principle disclosures made for a public purpose should be made in a way that protects the patient's confidentiality. The protection should include the concealment of individual names where concealment does not derogate from the purpose to be served by the disclosure.

We recommend the enactment of this principle in legislation.

17.10 Court Application for Order to Disclose (section 37(9), (10) and (11))

Section 37(9) empowers "the person or his legal representative" to apply to the court for an order directing disclosure. "Legal representative" is defined, in subsection (1)(b), for the purposes of section 37 to mean "an executor or administrator of the estate of a deceased person, the guardian or trustee of a dependent adult under the Dependent Adults Act or the guardian of a person who is a minor".

The court is empowered to direct disclosures which are not authorized by subsection (4) or any other law, or where the person in charge of the record refuses disclosure under subsection (6).

The words "the person or his legal representative" restrict the right to apply to the patient, although the order may direct release to "some other person". As a result, another person or agency wanting the information could not have its request reviewed without the cooperation of the patient or his legal representative.

Section 37(10) provides for the application to be made either (a) on motion in the course of proceedings to which the patient or his legal representative is a party or (b) by way of originating notice to the Court of Queen's Bench.

Section 37(11) requires the application to be made in private, and places the onus of showing why the order for disclosure should not be made on the person in charge of the record.

The requirement that a patient who has been refused access must seek an order of the court is unnecessarily burdensome and expensive. The patient, being in a special position, should have access to his record by right and we have so recommended (see 17.5.4).

We recommend that section 37(9), (10) and (11) should be repealed.

17.11 Notations on Record

17.11.1 Entry of Disclosure

We do not think it necessary to give the patient notice every time a disclosure is made under the authority of one of the provisions in section 37 which does not require the patient's consent. However, we do think that every disclosure should be entered on the patient's record. This means, in effect, that the form containing the authorization for the disclosure should be kept on the patient's file. Where the patient consents to the making of a disclosure, the form should also be kept on his file.

17.11.2 Correction of Record

According to the Hospital Accreditations Standards, the recordkeeper has a duty to keep accurate records. This means that obvious mistakes would be corrected in the ordinary course when the patient brings them to the attention of the recordkeeper.

The Task Force does not think that the patient needs to be given a right, in legislation, to correct inaccurate information on the record.

17.12 Sanctions for Wrongful Disclosure (section 37(5)

Section 37(5) makes it an offence for anyone knowingly and wilfully to release or disclose information obtained from records maintained in a diagnostic and treatment centre or from persons having access to it to a person not authorized to receive it, and imposes a fine of not more than $500 for an infraction. The penalty seems to apply to subsequent disclosures made by a person who has received information under the Act as well as to a wrongful disclosure by a person in charge of the record or a person gaining unauthorized access to it.

The Krever Commission (Krever Report, c. 14, rec. 13) recommended the creation of a statutory right permitting a patient whose health information has been disclosed without his consent to maintain a civil action for the *greater* of his actual damages or $10,000. The recommendation is contained in the chapter discussing the automobile casualty and liability insurance industry but seems to be intended to have a general effect. The action may be brought against:

(a) any health-care provider or other person under an obligation to keep health information about the patient confidential, who unjustifiably discloses his or her health information to a third person; and

(b) any person who induced anyone under an obligation to keep health information about a patient confidential, unjustifiably to disclose his or her health information.

The knowing and wilful contravention of the confidentiality protections afforded by the Act is a serious matter. Although we would not go the

extreme recommended by the Krever Commission of creating a civil right of action for $10,000 or more, we do believe that a maximum fine of $500 is not great enough. We recommend that $500 should be the minimum penalty imposed and that the maximum should be increased to $2,000. Our recommendation would emphasize the serious nature of the offence yet leave the court latitude to deal with the particular circumstances of individual infractions.

XVIII. TRANSFER OF PATIENT

18.1 Transfer to Another Facility (section 39)

Section 39(1) permits a board to transfer a patient to another facility, if otherwise permitted by law and subject to arrangements being made with the other board. The transfer is to be effected by the completion of a "memorandum of transfer" in the prescribed form.

Section 39(2) provides that the authority to detain the patient continues in force in the facility to which he is transferred.

The transfer may serve to bring the patient nearer to his home community, or to relatives, or to make available to him a program which is not offered in the facility in which he is detained at present.

We recommend that the section be preserved. The patient should, however, have the right to apply to the review panel for review of the decision to transfer him to another facility of the same designation (e.g. from one DF2 to another DF2, or from one DF3 to another DF3) where he objects to being moved.

The decision to transfer a patient from one level of facility to another level of facility (e.g. from a DF1 to a DF2, or from a DF2 to a DF3) will be reviewable by virtue of the issue of certificates to detain the patient at the new facility.

We have recommended elsewhere (see 10.4) that the patient's clinical record should accompany him on a transfer, and that recommendation should apply in this case.

18.2 Transfer for Hospital Treatment (section 40)

Section 40(1) authorizes a board to transfer a patient who needs treatment that cannot be supplied in the facility to a hospital and to return him to the facility on the conclusion of the treatment.

Section 40(2) gives the board of the hospital to which the patient is transferred, or a person designated by it, the powers of the board of a facility designated under the Mental Health Act in respect of the custody, control and treatment of the patient.

The section would apply where the patient needs medical attention for a physical ailment or condition, for example, surgical treatment of a hernia (*Re Osinchuk* (1983), 45 A.R. 132).

We recommend its continuation.

18.3 Transfer Into Alberta (section 41)

Section 41 permits the Director of Mental Health Services for the province of Alberta to issue a certificate when he has reason to believe that a person suffering from mental disorder may come or be brought into Alberta. The certificate takes effect as a conveyance and examination certificate if the person does come into the province.

The section would facilitate the transfer into Alberta of a person from the Yukon, the Northwest Territories, or another province, perhaps pursuant to an agreement entered into with another jurisdiction under the authority of section 3(2).

We agree with the procedure. The section should, however, be redrafted to refer to a "certificate of admission to a DF1" instead of to a "conveyance and examination certificate". Moreover, before the Director issues the certificate, he should be of the opinion based on reasonable and probable grounds that the person meets the criteria specified in the Mental Health Act for the issue of a certificate of admission to a DF1.

18.4 Transfer Out of Alberta (section 42)

Section 42 permits the Director of Mental Health Services to authorize the transfer of an involuntary patient from Alberta to another jurisdiction. Before the Director may issue a transfer, it must appear to him:

(a) that a formal patient has come or been brought into Alberta and his observation, care and treatment is the responsibility of another jurisdiction, or

(b) that it would be in the best interests of a formal patient to be cared for in another jurisdiction.

He must also first comply with the laws of the other jurisdiction, "with all necessary modifications".

We considered whether the patient ought to have the right to apply to the review panel for the review of a decision to transfer him out of the province. We decided against it on the basis that the decision is essentially an administrative one and the use of the power is rare.

XIX. ABSENCE FROM HOSPITAL

19.1 Leave of Absence

19.1.1 Authority to Grant Leave (section 38(1))

Section 38(1) authorizes the medical director of a facility to grant a leave of absence from the facility to an involuntary patient.

Leave of absence is not defined. We regard it as something more than the extension of a hospital privilege, for example, to walk on the grounds without supervision or take a trip into town to shop, attend a movie or go bowling. At the very least it seems to connote an overnight stay, perhaps a weekend visit with relatives. At most, it would embrace an opportunity for an involuntary patient to test out the improvement in his condition over an extended period of time in a realistic community setting rather than in the more contrived or artificial confines of a hospital.

We recommend that the medical director should continue to have the authority to grant a leave of absence to an involuntary patient.

19.1.2 Prescription of Terms and Conditions (section 38(2))

Section 38(2) empowers the medical director to prescribe terms and conditions for the leave. They may include a condition that the patient "remain under the supervision and subject to the treatment of any person or persons authorized by the medical director".

This provision facilitates the continued control over and recall, if necessary, of a patient whose condition may deteriorate in the community. It should be preserved.

19.1.3 Revocation of Leave (section 38(3))

Section 38(3) permits the board of a facility to revoke the leave of absence and recall the involuntary patient to the facility. The leave may be revoked where it appears to the medical director that "the patient's condition is presenting a renewed danger to himself or others". The revocation is effected by notice in writing given either to the patient or the person supervising him.

The grant of a leave of absence under section 38 of the Mental Health Act is analogous to the grant of a conditional discharge in the case of *X* v. *United Kingdom*. In that case, which was heard by the European Court of Human Rights, a patient had been discharged on condition that he live in his matrimonial home and attend a psychiatric out-patients clinic. He was subsequently recalled to hospital on the strength of information

from his wife that his health had deteriorated. The recall occurred without any prior medical examination being given, and without adequate explanation to either X or his solicitor of the reasons for the renewed detention, despite inquiries. X was held to be entitled to an opportunity to challenge the authority for the recall, both as to form and content, under Article 5(4) of the European Convention. Article 5(4), which has no direct counterpart in the Charter, guarantees a person who is deprived of his liberty the right to have the lawfulness of his detention decided speedily by a court.

The recall was found to have been justified on the facts. The fears expressed by the wife and the probation officer, together with X's background, were sufficient to give rise to an emergency justifying his recall. The subsequent confirmation by a hospital physician that X was suffering from a psychosis satisfied the general *Winterwerp* requirements.

What is important for us is that the patient was found to be entitled to challenge the decision which deprived him of his conditional freedom.

Section 38(3) does not specify on what evidence the medical director may form his opinion that the patient's condition has deteriorated. Nor does it give a patient whose leave has been revoked the right to a hearing to challenge the revocation. The decision to grant leave in the first place will be based on the personal knowledge and observation of the hospital staff. The foundation for revocation is less likely to be firsthand. It may be taken, for example, in response to the complaint of a family member about the patient's behaviour which is clouded by an inadequate or inaccurate perception.

The right to a hearing may be inferred from section 7 of the Charter which guarantees that a person shall not be deprived of life, liberty and security of the person except in accordance with the principles of fundamental justice. Whether or not this proves to be so, we believe that the patient should have a chance to state his view of the situation. He should not be left with the feeling that all control has been taken out of his hands. He is likely to be better disposed to further hospitalization and treatment if he feels that the decision to detain him has been made fairly.

We recommend that, upon the revocation of a leave of absence, the patient should have the right to apply to the review panel for the review of the case for detention.

The right should exist whether or not there has been a previous hearing in respect of the current detaining certificates. The review should be conducted in accordance with the recommendations in Chapter XIII, and the review panel should have the same powers of disposition including the power to adjourn so that the medical director may reinstate the leave (see 13.6.2).

19.1.4 Enforcement of Revocation (section 38(4))

If the patient refuses to return to the facility, or the notice under section 38(3) cannot be served, section 38(4) permits the medical director to declare the patient to be absent without leave and order any peace officer to return him to the facility. The medical director's order gives the peace officer the power to arrest, without warrant, for the purpose of returning the patient to the facility.

We recommend that the provision be continued, subject to the incorporation of our recommendations with respect to absence without leave (see 19.2).

19.1.5 Exemption from Authority to Grant Leave (section 38(5))

Section 38(5) exempts from the authority of the director to grant leave, an involuntary patient who is:

(a) detained pursuant to a warrant of the Lieutenant Governor, or

(b) remanded to a facility pursuant to the Criminal Code (Canada).

We recommend the continuation of this provision.

19.1.6 Calculation of Time While Patient on Leave

Time should continue to run on the detaining certificates while the patient is on leave. If the certificates expire while the patient is on leave, he should be free to continue in the community as an ordinary autonomous citizen, unimpeded by any terms and conditions attached to the leave by the medical director while the certificates remained in force.

19.2 Absence Without Leave

19.2.1 Order for Return of Involuntary Patient (section 43(1))

Section 43(1) authorizes the board of a facility to order any peace officer to return an involuntary patient who has left the facility without leave (compare section 38(4): see 19.1.4).

We recommend that the board should continue to have the authority to order the return of an involuntary patient.

19.2.2 Authority of Order (section 43(2))

Section 43(2) stipulates that on receipt of an order under section 43(1) or section 38(4), "every peace officer is empowered to arrest, without warrant, the person named in the order" and return him to the facility.

No time limit is specified for the arrest. We recommend that the authority of the order should be limited to the current period

of certification. That is to say, the order should expire with the current detaining certificates. It should not remain outstanding indefinitely. To this end, the order should state the date on which the current certificates expire.

We are content with the provision in other respects.

19.2.3 Calculation of Time While Patient Absent Without Leave (section 43(3))

Section 43(3) provides that an involuntary patient who is returned "may be detained for the remainder of the authorized period of detention to which he was subject when his absence was discovered".

The effect of this provision seems to be that the running of time on the detaining certificates is suspended as soon as the absence without leave is discovered under section 43(3) or the leave of absence is revoked under section 38(4).

We do not agree that this should be the case. Time should continue to run on the detaining certificates irrespective of the patient's absence from the hospital. If the patient is returned before the certificates expires, and the conditions for detention continue to exist, the detention can be continued by the issue of new certificates. If he is not returned before the certificates expire, and the conditions for detention are present, he ought to be apprehended pursuant to a certificate of admission to a DF1 or a judicial warrant or the exercise of the peace officer's power, as is appropriate to the circumstances.

XX. DISCHARGE

20.1 Authority to Discharge (section 34(3))

Section 34(3) permits the board of a facility to discharge an involuntary patient who is no longer a danger to himself or others. Upon discharge the admission certificates or renewal certificates, as the case may be, are deemed to be cancelled. (If the patient wishes to remain in the facility as a voluntary patient and the board is willing to have him, the treatment may be continued on this basis without the necessity for discharge (see 7.6).)

Section 34(3) should be retained.

20.2 Notice of Discharge (section 33(1))

Section 33(1) obliges the board of a facility, where possible, to give notice of the discharge of an involuntary patient to the nearest relative, "if the person discharged agrees", and to the referring source. The notice is to state whether a certificate of incapacity under the Dependent Adults Act exists with respect to the person (see 21.1.3 for a discussion of certificates of incapacity).

We recommend that notice to the nearest relative should continue to be required subject to the consent of the patient. A person named by the patient as his representative should be notified on the same basis.

We regard the referring source as part of the treatment regime. Notice to the referring source should therefore continue to be mandatory, occurring irrespective of the will of the patient. We would, however, reword the provision to require notice "to the referring physician or other referring source".

We would permit notice to be given to a physician, mental health worker or agency with which the patient intends to develop a continuing therapeutic relationship. Notice in this circumstance should be given only with the patient's consent.

The reference to the existence of a certificate of incapacity under the Dependent Adults Act should be retained.

20.3 Refusal of Patient to Leave (section 33(2), (3), (4) and (5))

Section 33 (2) authorizes the board to require a patient who has been discharged and refuses or is unwilling to leave the facility to be removed by:

(a) any person who is liable for the payment of expenses incurred with respect to the former patient pursuant to section 45(1), or

(b) the Minister of Social Services and Community Health.

Section 33(3) provides for notification by registered mail to the person responsible for the removal. The removal is to take place within 10 days from the receipt of the notice.

Section 33(4) requires a copy of the notice given under section 33(3) to be mailed to the Director of Mental Health Services.

Section 33(5) makes it an offence to fail to comply with the notice. The offence is punishable by a fine of not more than $50 and in default of payment imprisonment for a term not exceeding 10 days.

These provisions appear to facilitate efficient hospital administration and should be preserved for that purpose. We hope that resort to them is infrequent.

20.4 Discharge Planning

It has been submitted to us:

(a) that the patient should have a right to a documented discharge plan which designates a person or community agency to provide follow-up services and includes appropriate clinical information and recommended treatment; and

(b) that the responsibility of the facility board for discharge planning should be legislated.

The Mental Health Act is silent about discharge planning. In Saskatchewan, legislation requires the patient's circumstances in the community to be considered before he is discharged.

Section 35(2) of the Saskatchewan Mental Health Act, R.S.S. 1978, c. M-13, stipulates:

> ... no patient shall be discharged from an in-patient facility if upon investigation the medical officer in charge is satisfied that the conditions in, or the environment of, the proposed residence of such person are unsuitable for his return thereto.

Section 22 of the Saskatchewan Regulations requires that:

> ... the decision as to when to discharge a patient or release him on trial leave shall take into account the circumstances in the community to which he must return and the facilities available to assist in his rehabilitation.

Planning to ease the patient's transition into the community is to be encouraged as good medical practice. We do not, however, think that discharge planning should be required by legislation. The acceptance of a plan, both by the patient being discharged and by the physician or agency in the community offering the service, should be voluntary. Whereas the imposition of terms and conditions is appropriate on leave of absence, the patient should be free to make his own decisions on discharge.

XXI. SPECIAL CONSTITUENCIES

21.1 Dependent Adults

21.1.1 Persons Hospitalized on Consent of Guardian

The Dependent Adults Act, R.S.A. 1980, c. D-32, provides, in section 6, for guardianship in cases where a person is unable "to care for himself" and unable "to make reasonable judgments in respect of all or any of the matters relating to his person". Obviously, this definition includes many persons who are mentally disordered as defined in the Mental Health Act, as well as the mentally retarded and other persons to whom the Dependent Adults Act is intended to apply.

One of the powers listed in section 9(1) of the Dependent Adults Act which may be granted to a guardian is the power, in paragraph (h), "to consent to any health care that is in the best interests of the dependent adult".

In the recent case of *Re Osinchuk* (1983), 45 A.R. 132 (Alta. Surr. Ct.), Mr. Justice D.C. McDonald refused to appoint a guardian with the power to consent to matters of mental health care in respect of a person hospitalized pursuant to certificates issued under the Mental Health Act. He found that sections 19 and 20 of the Mental Health Act confer an implied authority on the facility to care for and treat illnesses related to the mind without the consent of the patient.

We agree that the authority is this broad. We do not, however, think that its exercise should go unchecked. The participation of the patient in treatment decisions is important. Where the patient is incapable of participating for himself, a guardian should act in his place. Our recommendation to require the review of treatment to which the patient or a person on his behalf objects will help to fill any hiatus left by the absence of a guardian with power to make mental health care decisions.

Some guardians appointed under the Dependent Adults Act have been granted the power to consent to mental health care, the decision in *Re Osinchuk* notwithstanding. Several submissions raised a problem relating to this power. Its exercise to hospitalize a dependent adult for mental disorder permits what in effect may be a compulsory confinement at a facility of a person who may not normally meet the criteria set forth in the Mental Health Act for involuntary hospitalization, merely upon the guardian consenting to such confinement.

We recognize that the ability to deliver a person to a facility for treatment solely as a result of the powers conferred upon a guardian in the Dependent Adults Act in cases where the person would not otherwise be certifiable is contrary to the scheme and the intent of the legislation in many cases. It is not likely

accurate to state that such a patient would usually be "voluntary" in the true sense of the word.

Accordingly, while the Task Force believes that review of the provisions of the Dependent Adults Act is beyond the scope of its terms of reference, something should be done to correct what we see as a potential abuse. It is our recommendation that persons who become patients at any facility solely as a result of the provisions and powers contained in the Dependent Adults Act should to all intents and purposes be treated as involuntary patients, whether or not they would be certifiable under the provisions of the Mental Health Act. As such, they would be entitled to all the rights and protections of the Mental Health Act, including such rights as the right to advocacy services, the right to independent psychiatric opinions where permitted, and rights of access to the review panel for a decision on treatment or the need for hospitalization. These rights should be exercisable by the patient himself or by any other person on his behalf.

A dependent adult, like any other person, may be hospitalized by the issue of certificates under the Mental Health Act where he satisfies the requisite conditions. If his guardian consents to the hospitalization and necessary treatment, certificates will not be required. If, however, the guardian refuses his consent, certificates can be issued. If the guardian objects to the treatment given or proposed to be given to a certified patient, his objection on behalf of the patient should be the basis for review of the treatment by the review panel (see 15.4).

21.1.2 Persons Hospitalized Under a Compulsory Care Order

Sections 10.1 to 10.8 of the Dependent Adults Act permit a dependent adult to be placed in "compulsory care". Section 10.3 states that a "compulsory care order" made by a Court under section 10.1 provides authority to apprehend and convey to and confine a dependent adult at a "place of care". A "place of care" is defined in section 5.1 of the Regulations to include the two Alberta Hospitals. The result is that, contrary to the intended purpose of the hospitals, they may be required to accept persons who have not been examined by their medical staff, may not be suffering from a mental disorder, and who otherwise would not be admitted. Further, the relevant provisions in the Dependent Adults Act have been criticized on the basis that they are rather imprecise as to the nature and extent of medical input required prior to a court ordering the issuance of a compulsory care order. The medical staff of the facility who would ordinarily make the decision to admit a patient are not necessarily involved in the proceedings leading to the compulsory care order.

We regret that we cannot suggest a solution to this problem. We agree that it is not entirely appropriate to use designated

facilities, particularly the two Alberta Hospitals, for the detention of the non-mentally ill. Presumably, in this context, the use of the hospitals for compulsory care is being limited to cases where the dependent adult is regarded as dangerous and the security and staffing of the hospitals enables them to deal with difficult persons who cannot be contained in other institutions or care facilities in the province. We do not believe that the practice should be encouraged, but in some situations where a dangerous person is not suffering from a mental disorder, we unfortunately see no alternative.

21.1.3 Certificates of Incapacity

Section 50 of the Dependent Adults Act authorizes two physicians, "after separate examinations of an adult person who is resident for any period of time in a facility at the time the examinations are made", to certify the incapacity of the person "to make reasonable judgments with respect to all or any matters pertaining to his estate". Upon certification, section 51 requires one of the physicians to notify the Public Trustee and the person's guardian or, if he has no guardian, his nearest relative. By section 52, the Public Trustee becomes the trustee of the estate of the person named in the certificate unless a trusteeship order is already in existence.

Section 4 of the Regulations names the Alberta Hospitals at Edmonton and Ponoka as facilities for the purpose of the Dependent Adults Act, so the provisions for the issue of a certificate of incapacity would apply to a patient hospitalized under the Mental Health Act. They appear to apply to both voluntary and involuntary patients in these institutions since the only requirement is that the person be an adult resident in a facility at the time of the examinations.

Although the Dependent Adults Act provides, in section 53, for review of the certificate of incapacity by an appeal panel at least once every two years on the application of the Public Trustee, there is no provision for review at the instance of the patient nor does the patient have a chance to be heard prior to the issue of the certificate. Section 54 provides that the certificate may be terminated by subsequent certificates issued by two physicians who have come to the opinion that the person is now "able to make reasonable judgments with respect to matters pertaining to his estate". Section 57 provides for termination by a trusteeship order or other order of termination made by the Court of Queen's Bench, or by an appeal panel on the Public Trustee's application.

We have not been asked to recommend the reform of the Dependent Adults Act. It seems to us, however, that the patient should have an opportunity to be heard prior to the issue of a certificate of incapacity, or before it takes effect, or to challenge it by initiating a hearing to review it at stated intervals. Indeed,

the existing provisions may offend section 7 or other rights guaranteed by the Charter. We therefore suggest that the government consider amending the provisions to allow the person named in the certificate or someone on his behalf to apply for a hearing into its merits.

21.1.4 Rights of Hospitalized Dependent Adults

The rights of dependent adults should be included in the statement of patients rights which we recommend be posted in prominent locations in all wards throughout facilities, and in the booklet of rights which we recommend be distributed to patients on admission and available on every psychiatric nursing unit (see chapter XII).

21.2 Children and Adolescents

21.2.1 Parental Responsibility

As a general rule, medical treatment is given only with the consent of the patient. In the case of a person under 18 years of age, the consent is usually given by a parent or guardian. A child approaching adulthood may be capable of fully appreciating the nature and consequences of particular medical treatment. Where he is capable, the law permits him to make his own decisions about medical treatment, and the consent of the parent or guardian ceases to be effective.

The status of the patient as voluntary or involuntary is rarely an issue with younger children, but as they become more independent it can become a problem. This occurs in inpatient treatment because of the difficulty in keeping an unwilling patient in a general hospital in an open unit. Most hospital wards do in fact have methods for detaining uncooperative children (though these methods often involve the extra provision of scarce personnel).

21.2.2 Statutory Provisions for Compulsory Confinement

The Mental Health Act

The Mental Health Act mentions minors only twice: (1) in section 1(j) where it is specified that the "nearest relative" of a child who is a ward of the Crown under the *Child Welfare Act* is the Minister of Social Services and Community Health; and (2) in section 37(1)(b) where, with respect to the confidentiality of records, "legal representative" is defined to mean "the guardian of a person who is a minor".

There is no mention of a lower age limit for the application of the Act so that, theoretically at least, it applies to children and adolescents.

The Child Welfare Act

A child who is a ward of the Crown may be confined in an institution for specified periods of time under the compulsory care provisions of the Child Welfare Act, R.S.A. 1980, c. C-8, ss. 77-90. The confinement may be authorized in one of two ways. First, under section 79(1), the Director of Child Welfare may issue a "compulsory care certificate" when he:

(a) has reasonable cause to believe that a child who is a ward of the Crown

  (i) is suffering from an emotional or behavioral disturbance, and

  (ii) is in a condition presenting a danger to himself or others or is otherwise out of control,

and

(b) is of the opinion that it is in the best interests of the child that the child be confined in an institution.

Alternatively, under section 78(3), a judge of the Provincial Court or the Court of Queen's Bench may make a "compulsory care order" when he is satisfied that:

(a) the child is in a condition presenting a danger to himself or others or is otherwise out of control, and

(b) it is in the best interests of the child that the child be confined in an institution.

While the child is confined under either a certificate or an order, section 85 requires that he receive:

(a) the diagnostic and treatment services that the child is in need of and the staff of the institution is capable of providing and is able to provide, and

(b) the level of security that is reasonably required for the confinement of the child.

The new Child Welfare Act introduced as Bill 105 (see 17.7.2) retains the concept of compulsory care but modifies the details of the provisions. The criteria proposed, in sections 39(1) and 40(2), for certificates and orders are that:

(a) the child is suffering from a mental or behavioural disorder,

(b) the child is in a condition presenting a danger to himself or others, and

(c) it is necessary to confine the child in order to protect the survival, security or development of the child.

By section 41(2), the institution to which the child is admitted is obliged to provide:

(a) the diagnostic and treatment services that the child is in

need of and the staff of the compulsory care institution has the resources to provide, and

(b) the level of security that is reasonably required for the confinement of the child in accordance with the regulations.

The criteria for compulsory confinement and the obligations of the institution in which the child is confined under both the existing and the proposed Child Welfare Acts are remarkably similar to the criteria for compulsory hospitalization set out in sections 18(1) and 20(1) and the obligations of the facility specified in section 13 of the existing Mental Health Act. We have recommended that the legislation should require a higher standard of treatment (see 15.2 and 6.4).

21.2.3 Current Practice

Management of Psychiatric Disturbances in Children

Most emotional disturbances in children can usually be managed by outpatient treatment. In some cases, the family (the most common source of stress in the child's life) is unwilling or, because of the degree of its own disturbance, unable to cooperate with the treatment efforts. In other cases, the child's behaviour may be sufficiently troublesome for the family to feel unable to cope any longer.

Where residence outside the home is recommended, child welfare facilities operated by the Department of Social Services and Community Health are frequently used instead of psychiatric inpatient facilities which are in short supply in most centers in Alberta. This is not always undesirable. In many situations, the child's problems can be helped by skilled staff in a non-hospital setting. Furthermore, hospitalization is not always the best overall management when the child has to be separated from the family. The child's disturbance tends to be perceived as sickness, with the expectation on the family's part that it will be cured in hospital – the usual expectation of a hospital. This removes the onus of change from the family, often the place where change is essential if the child is to continue to improve.

However, it must be emphasized that there are many children in child welfare facilities whose degree of disturbance merits psychiatric hospital treatment, and for whom the child welfare staff feel unable to provide optimal care. The Cavanagh Commission identified one reason for this. In discussing standards of treatment for children in care, the Report states (at 77): "In the interests of economy there is sometimes a tendency to employ the cheapest possible help which tends to mean also the most poorly trained help". The Report is quick to add that "this is not always so – many are well trained". It goes on to point out (at 79) that sophisticated treatment facilities which deal with very difficult problem children have need of the serv-

ices of very qualified people in various fields, although not necessarily on a full-time basis.

Facilities Available

Mental Health Facilities. In practice, the Mental Health Act is seldom used for minors with psychiatric problems. One reason is that the facilities designated for involuntary hospitalization under the Act do not offer programs and services for children. A child, or more likely an adolescent, cannot be committed as an involuntary patient if there is no designated facility to admit him. (A second reason is that, as a matter of management, children are most often hospitalized on the consent of their legal guardians (see 21.2.1)).

The two Alberta Hospitals are organized to serve the needs of mentally disordered adults, although on a rare occasion they may admit an older adolescent. In the past, both of the provincial psychiatric hospitals had adolescent units: Apollo at Alberta Hospital, Ponoka; and Kennedy Hall at Alberta Hospital, Edmonton. However, both adolescent units were closed down in the 1970's. Whatever the reasons for these closures, it cannot be emphasized too strongly that the scarcity of psychiatric beds for adolescents has made the task much more difficult for those few psychiatrists working with this population, and attempting to cope with their widespread problems. If facilities were available, then the Mental Health Act might be invoked more frequently for the treatment of psychiatrically ill adolescents.

Apart from the absence of any designated facilities for children and adolescents, there is generally an inadequate supply of psychiatric services and inpatient facilities in the province. This shortage is documented at length in each of the recent surveys of psychiatric services in Alberta (McKinsey Report; Clark Institute Report). The incidence of cases where the family is or feels unable to cope with a child's disturbed behaviour far exceeds the psychiatric inpatient facilities available.

Child Welfare Facilities. The Department of Social Services and Community Health operates a wide range of living accommodations and programs for children in the care of the Director of Child Welfare, whether under custody by agreement with the child's parents or guardian or under a temporary or permanent wardship order. These include foster homes, group homes, residential treatment units and the compulsory care institutions referred to previously. The arrangements entail varying degrees of supervision exercised by persons of varying skills.

The only "closed" facilities for children and adolescents suffering from mental disorder or emotional disturbance are the compulsory care placements available for wards of the Crown or juvenile delinquents who are subject of compulsory care under the Child Welfare Act. Closed child welfare treatment

facilities include Westfield in Edmonton and the William Roper Hull Home in Calgary. Other closed facilities are the Youth Development Center in Edmonton and the Youth Assessment Centers (Y.A.C.'s) in other locations around the province. None of these facilities is a psychiatric unit and the extent of medical care is usually limited to consultant physicians. As we have said, there are many children in these and other child welfare placements whose degree of disturbance merits psychiatric hospital treatment.

One disadvantage of the present system is that child welfare facilities including, most importantly, the maximum control afforded by compulsory care are available only for children in the care of the Director of Child Welfare. Wardship is usually reserved for children without parents, or whose parents have "neglected" them. The children of loving and conscientious parents may also suffer from mental disorder. It should not be necessary for the Director of Child Welfare to take over the parental role for these children to receive needed treatment.

The Cavanagh Commission urges that the emphasis in child welfare should be on preventive work so that fewer children are taken into care. It also recommends (in chapter 26) the repeal of the provisions relating to compulsory care, regarding their purpose to be to "legitimize the confinement of juvenile delinquents" made temporary wards of the province instead of being sentenced.

The Cavanagh Commission believes that the authority of a parent is sufficient to provide treatment to disturbed children and adolescents, saying (at 194):

> If a child becomes insane or disturbed so that it is necessary to confine him and treat him, a parent can and has the responsibility to do that and does not need the provisions of a compulsory care certificate in the Child Welfare Act.

It asserts (at 195) that compulsory care often fails to direct a child to needed treatment:

> The use of certificates and judge's orders is also an arbitrary and expeditious means of disposing of an acting out child without very much consultation with experts and without it being established that the institution is appropriate for the problem presented.

We question whether the authority of a parent will always be sufficient to prevent a disturbed or mentally disordered child from running away or engaging in other unwanted behaviours. The law imposes limits on the extent to which a child can be forcibly restrained or confined.

Furthermore, parental control becomes more difficult as the child grows older.

While we believe that, ideally, psychiatrically disturbed children should be cared for in psychiatric treatment centers rather than under compulsory care in child welfare facilities, we recognize the importance of compulsory care units as facilities for detaining severely disturbed and mentally disordered young persons when no other facilities are available. The adoption of the Cavanagh Commission's recommendations should not exacerbate the already grave lack of facilities for children and adolescents needing intermediate or long term compulsory hospitalization.

Assessment

The lack of comprehensive psychiatric assessment services for children and adolescents in Alberta is documented in the McKinsey and Clarke Institute studies.

Even within the child welfare regime there is difficulty selecting which children should be managed in hospital and which should be placed in other facilities. Assessments are made on an individual basis in hospital units by child psychiatrists. They are also made in Youth Assessment Centers, although the Cavanagh Commission observes (at 79-81) that the Y.A.C.'s have come to be used as holding facilities more than as assessment centers. Moreover, the Department, through its Placement Committee, may require an assessment as the basis for deciding on admission to one of its facilities. Liaison between the child psychiatrist and the social services network is not always easy and there is an overall lack of comprehensive assessment services in the province. If such services were available, then there could be a more thorough screening of children, avoiding inappropriate referral to the child welfare system.

21.2.4 Task Force Recommendations

Application of the Mental Health Act

We do not propose the introduction of any lower age limit for the Mental Health Act. Its provisions should continue to be available, where needed, for the compulsory hospitalization of children and adolescents as well as adults.

Obligation of Minister to Establish Facilities

As a matter of general principle, we believe that psychiatric care and treatment for children and adolescents should be available independently of the child welfare system. We recognize that often the family will be part of the child's problem and it is likely that a significant number of children in the child welfare system are disturbed to some degree. The services, accommodation and facilities available for child welfare are an important component in meeting the needs of ıildren overall. Nevertheless, it is inappropriate to require a child to be placed

in government custody or wardship to gain admission to the only facilities available for the extended supervision of mentally disturbed young persons whose main requirement is psychiatric care.

If the psychiatric assessment process were improved, and if there were sufficient psychiatric facilities for children, then it could be anticipated that there would be a reduction in the number of children made subjects of compulsory care. Some of these children are suffering from emotional problems more effectively dealt with in a psychiatric unit, and would be directed into such a service at the time of assessment. As things stand at present, however, compulsory care premised on wardship is often the only method available to help children who abscond from open units.

Earlier in our Report (see 6.3), we asserted that "[t]he establishment of adequate facilities at each level, throughout the province, is imperative to a well-functioning system capable of responding to the needs of severely mentally disordered persons". We recommended that the Minister should have the duty of ensuring the establishment and continuance of designated facilities at each level (DF1, DF2 and DF3) and that the duty should be legislated. We now recommend that the Minister's legislated duty should include the establishment and continuance of psychiatric facilities designated for the intermediate and long term care and treatment of severely mentally disordered children and adolescents.

Rights of Hospitalized Children

We have recommended that a dependent adult hospitalized on the consent of his guardian should be regarded as an involuntary patient (see 21.1.1). He would thereby be entitled to all the rights and protections of the Mental Health Act. This includes the right to advocacy services, the right to independent psychiatric opinions where permitted, and rights of access to the review panel for a decision on treatment or the need for hospitalization.

In principle, a minor should enjoy the same rights and protections. We recommend that children 16 years of age or over who are hospitalized in a designated facility on the consent of a parent or guardian should be visited automatically by the advocacy service for an explanation of rights. The age of 16 was recommended by the Institute of Law Research and Reform (Report No. 19, *Consent of Minors to Health Care,* December 1975) as the general age at which a valid consent by a minor to medical treatment should be fixed.

We think that the occasions when a mentally disordered child below the age of 16 will be able to make decisions or exercise rights for himself will be rare. We therefore would not stretch the resources of the advocacy service to require automatic

interviews of children below this age. However, a younger child who can initiate a case worthy of representation should be entitled to the assistance of the advocacy services to pursue it.

We recommend, in addition, that a minor should be entitled to have his competence to give a valid medical consent determined by the review panel. If he is competent and unwilling to continue treatment in the facility, he should be released unless he satisfies the conditions for compulsory hospitalization. In the latter event, certificates may be issued and the hospitalization continued on their authority.

The rights of children of all ages should be included in the statement of patients rights which we recommend be posted in prominent locations in all wards throughout the hospital, and in the booklet of rights which we recommend be distributed to patients on admission and available on every psychiatric nursing unit (see chapter XII).

21.3 Mentally Disordered Offenders

21.3.1 Prisoners Remanded for Psychiatric Observation

Section 36(1) of the Mental Health Act refers to the hospitalization, in a facility, of a person remanded, pursuant to the Criminal Code (Canada), to custody for observation. The person "may be admitted to, examined and detained in and discharged from a facility in accordance with the law".

The authority to remand a prisoner for observation to determine his fitness to stand trial is contained in section 543 of the Criminal Code.

Section 36(1) is an enabling provision. It enables provincial mental health facilities to be used to carry out the provisions of the criminal law. It should be retained.

21.3.2 Prisoners Held Under Lieutenant Governor's Warrant

Section 36(2) refers to the hospitalization, in a facility, of a person detained pursuant to the Criminal Code (Canada) under the authority of a Lieutenant Governor's warrant. The person "may be admitted to, examined, treated and detained in and discharged.. in accordance with the law".

Lieutenant Governor's warrants issue when an accused person is found unfit to stand trial under section 543 of the Criminal Code and when an accused person is found not guilty by reason of insanity under section 16 of the Criminal Code. There are, of course, a number of provisions in the Criminal Code dealing with the defence of insanity. They are beyond our scope.

Where the Lieutenant Governor is satisfied that a serving prisoner is "insane, mentally ill, mentally deficient or feebleminded", section 546 of the Criminal Code permits him to order

the prisoner to be transferred to a place of "safekeeping". Section 546 almost implicitly suggests that mental health facilities can be used at the pleasure of the Lieutenant Governor as an alternate type of prison for difficult prisoners suffering from any type of mental problem. We do not believe that this is appropriate (see 21.3.3).

Section 547 of the Criminal Code authorizes the Lieutenant Governor to appoint a board of review to assess the cases of prisoners held in "safe custody" in a provincial psychiatric facility, or elsewhere, under Lieutenant Governor's warrant and to make recommendations about them in the interests of the recovery of the prisoner and of the public.

Alberta Hospital, Edmonton operates a secure forensic psychiatric unit for these prisoners.

Section 36(2), like section 36(1), is an enabling provision. The authority to admit prisoners who are held under Lieutenant Governor's warrant pursuant to the provisions of the Criminal Code to a provincial psychiatric facility for treatment should be continued.

21.3.3 Other Prisoners

Prisoners on remand but otherwise fit to stand trial may, nevertheless, be suffering from mental disorder. (The test for fitness to stand trial relates to the ability to instruct counsel.) Convicted prisoners serving sentences may also suffer from mental disorder, as is recognized in section 546 of the Criminal Code (see 21.3.2). Provincially, section 9 of the Corrections Act permits a prisoner who requires treatment pursuant to the Mental Health Act to be transferred from a correctional institution to a designated facility.

We received some submissions which complained about a lack of accessibility to designated facilities by prison officials on behalf of serving prisoners, including prisoners remanded before trial. Mentally ill prisoners can become very disruptive while in prison. We were told that there was a tendency on the part of the designated facilities to ignore the needs of prison and remand facilities in the Edmonton area, for example. This was disputed in a submission provided to us on behalf of Alberta Hospital, Edmonton. We were really not in a position to assess the facts of the situation, but it did appear to us that there was lack of communication between the Alberta Hospital, Edmonton and Edmonton area prison facilities.

Prisoners should be entitled to medical and dental treatment, including appropriate treatment for mental illness. When it becomes apparent that a mentally disordered offender requires committal to a facility for treatment, the principles for committal should apply in the same manner as they apply to any other person who is mentally ill but not a prisoner. A facility should accept or reject him for treatment in accordance with

its policies applicable to other patients. That is to say, when a prisoner on remand or convicted and serving time in a provincial correctional institution suffers from mental disorder and meets the criteria in the Mental Health Act for compulsory hospitalization, certificates should be issued and he should be detained in a suitably secure forensic unit in a facility. When a mentally disordered prisoner is willing to be hospitalized and a facility is willing to admit him, he should be eligible for hospitalization as a voluntary patient, again in a secure forensic unit.

We do not believe that a case can be made for granting prisoners preferential access to mental health facilities. On the other hand, we understand that there is a disturbingly high incidence of mental illness and disorder among prisoners and that certain conditions may cause great disruption at prison facilities, which could potentially lead to chaos.

Subject to the provisions of the Criminal Code and correctional legislation, patients who are prisoners should have the same rights as patients who are not prisoners, including access to review panels.

One difference is that upon the improvement of his condition, the prisoner should be returned to prison, if time remains in his sentence, or be otherwise discharged in accordance with penal practices. Section 29 of the Mental Health Act covers this situation. It permits a convicted prisoner who is sent to a facility for treatment to apply to the review panel for an order transferring him back to a correctional institution. The review panel has the authority to make the order for transfer. It also has the authority to cancel admission or renewal certificates if they have been issued. The board of the facility has a duty to comply with the order. Section 29 should be retained.

21.3.4 Outpatient Examination and Treatment

Section 35(1) of the Mental Health Act empowers a judge to order a person who appears before him to attend a facility or service as an outpatient for examination. The person must be charged with or convicted of an offence. The judge must have reason to believe that he suffers from mental disorder.

Section 35(2) requires a written report on the mental condition of the person to be made to the judge after the examination.

Section 35(3) empowers the judge to order the person to attend a facility or service for treatment as an outpatient if the report indicates that treatment is needed.

Section 35 likely applies only to provincial offences, since legislative competence over criminal matters lies with the federal Parliament. We have little information on its operation and suspect that it is rarely, if ever, used. The administrative structure to make it work may not be in place. For example, facilities

may not be accustomed to performing outpatient examinations. Then, too, the section does not impose an obligation on a facility to examine or treat in accordance with the order. The obligation is only on the person to attend.

We can imagine circumstances where an order would be useful. We recommend that the section be continued and that, if required, steps be taken to make it operational.

XXII. MISCELLANEOUS ADMINISTRATIVE MATTERS

22.1 Director of Mental Health Services

Section 2 of the current Mental Health Act authorizes the appointment of a Director and Associate Director of Mental Health Services. The qualifications for each post are not specified.

We believe that the Director should be a psychiatrist and that this should be specified by the legislation. Generally speaking, we believe that when medical and administrative views are in conflict, medical views should prevail. This would be best achieved by having a psychiatrist in the senior position.

Further, under the current mental health delivery system, and under the system which we propose, the central component in delivery of health services is the physician, preferably a psychiatrist. Professionals sometimes have difficulty in taking leadership from non-professionals. Without expressing sympathy for this situation, we believe that it is important that it not be an impediment to an effective delivery system.

Purely administrative matters can be handled by the Associate Director.

22.2 Role of Mental Health Councils

Sections 5 and 6 of the Mental Health Act set out the composition and duties of the Provincial Mental Health Advisory Council (PMHAC) and the Regional Mental Health Councils. The establishment of these Councils was one of the more innovative provisions of the 1972 Mental Health Act.

The Councils contain representation from a variety of interested professional groups, other groups having an interest in the mental health delivery system, and the public at large. By a 1981 amendment to the Mental Health Act, a member from each Regional Council, also sits on PMHAC. A few professional or other interest groups which are not represented told us that they would wish to be represented on an expanded PMHAC.

The Task Force believes that the concept of the Mental Health Councils should continue. PMHAC provides for public input into the mental health system. It can be an effective "sounding board" for government programs and policy. We feel that no dramatic changes ought to take place in program or policies without the government first consulting PMHAC. Occasionally, time constraints may make it impossible for PMHAC to give adequate consideration to problems which require immediate solutions. However, the views of the Council should be obtained on all matters pertaining to long-range planning and policies of the mental health delivery system.

The Regional Councils enable the public to respond to local concerns as well as provincial issues.

The Task Force has some concern about the size and composition of these Councils. They tend to be large and somewhat unwieldy. To the

end that they might become more efficient and effective in their tasks, we recommend that they be reduced in size.

PMHAC should consist of a chairman, appointed by the Lieutenant Governor in Council, and 14 other members. The members should be:

(a) one member from each of the six Regional Councils, selected by the Council he represents, and

(b) eight additional members appointed jointly by the Minister of Social Services and Community Health and the Minister of Hospitals and Medical Care.

The members should represent a broad area of interest and expertise in the mental health field, including consumers of mental health services, so that their collective views achieve a balanced perspective. The Director of Mental Health Services and an appropriate representative from the Department of Hospitals and Medical Care, or their designates, should be made ex officio members of PMHAC. Alternate members should be chosen as they are at present.

The Regional Councils should consist of between 5 and 10 members each, appointed by the two Ministers. As with PMHAC, membership should consist of a balanced group of interested people with expertise in the area. The Councils should be six in number and represent the Northwest Region, the Northeast Region, the Edmonton Region, the Central Alberta Region, the Calgary Region, and the Southern Region. The Regional Directors, or their designates, should be ex officio members of these Councils.

The Regional Councils should be authorized to consult or advise the Minister on matters directly relating to their region. When necessary they should be able to bring in outside expertise in order to make informed decisions. Where matters are of a provincial nature, they should report to PMHAC. To help the Councils fulfill their role, we recommend that section 6(4) of the Mental Health Act be rewritten to permit a Council to "consult with and advise any person, agency, organization or other body on any aspect of mental health that it considers necessary or desirable".

Finally, we feel that both the Provincial and Regional Councils require adequate funding to carry out their duties in a responsible and worthwhile manner.

22.3 Definition of "Psychiatrist"

For the sake of clarity in the legislation, we believe that the term "psychiatrist" should be defined. An appropriate definition of "psychiatrist" would be a "medical practitioner recognized by the College of Physicians and Surgeons as a specialist in psychiatry".

22.4 Definition of "Nearest Relative"

Section 1(j) attempts to define and place in order of priority the nearest relative of an involuntary patient. We believe that the section is deficient in that it omits a common law spouse from the definition of nearest relative, and we recommend that common law spouse be added with

the same status as legal husband or wife in that section. We would adopt as a definition of common law spouse that contained on section 1(f) of the Worker's Compensation Act, as follows:

> 'Common law spouse' includes any man or woman who, although not legally married to a person, lives or cohabits with that person as a spouse of that person and is known as such in the community in which they have lived.

22.5 Liability for Hospital Charges

We have no objection in principle to the content of sections 45 and 46 of the legislation. However, generally speaking, we do not believe that involuntary patients should be subjected to any expense arising from or connected with hospitalization.

The current Mental Health Act regulations permit the implementation of a charge of $8.00 per day to voluntary patients who reside in the facility for a period beyond 120 consecutive days. We are advised that the amount of revenue gathered by this provision has been minuscule in comparison to the operating costs of the hospitals. Further, collection of the charge is not universal and is waived in many cases where it is felt that to collect it would be detrimental to the patient's health. Often, collection is postponed until the death of the patient, whereupon payment is extracted from the patient's estate.

In our view, voluntary patients in mental health facilities should be treated in the same fashion as hospital patients generally throughout the province. With the exception of recent legislation permitting the charging of "user fees" by general hospitals, there was no analogous charging provision applicable to general hospitals. It is our recommendation that the $8.00 per day charge for voluntary patients be discontinued until the situation with respect to user fees in other hospitals generally is clarified.

22.6 Name of Act

We recommend that the name of this legislation be changed to "The Mental Disorders Treatment Act". The title of the existing Act is a misnomer. It does not really deal with mental health but rather with a group of individuals suffering from severe mental disorders. Unfortunately, we have not been able to formulate a way of legislating mental health. Instead, we have limited ourselves to delineating those individuals whose severe mental disorders necessitate detention and/or treatment, even though they themselves do not consent. We have also proposed legislation which we regard as essential to protect the civil rights of such patients.

APPENDICES

APPENDIX "A"

List of Submissions

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APPENDIX "B"

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GOVERNMENT OF THE PROVINCE OF ALBERTA

MENTAL HEALTH ACT

CHAPTER M-13
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OF ALBERTA
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MENTAL HEALTH ACT

CHAPTER M-13

HER MAJESTY, by and with the advice and consent of the Legislative Assembly of Alberta, enacts as follows:

Definitions

1 In this Act,

(a) "admission certificate" means a certificate issued pursuant to section 18;

(b) "board" means

(i) the board of an approved hospital under the *Hospitals Act*, that is designated as a facility, or

(ii) if a facility is not an approved hospital under the *Hospitals Act*, the person in charge of the facility;

(c) "conveyance and examination certificate" means a certificate issued pursuant to section 14;

(d) "Council" means the Provincial Mental Health Advisory Council established pursuant to section 5;

(e) "Director" means the Director of Mental Health Services;

(f) "facility" means a place or part of a place designated by the regulations as a facility;

(g) "formal patient" means a person admitted to and detained in a facility pursuant to admission certificates or detained in a facility pursuant to renewal certificates;

(h) "mental disorder" means lack of reason or lack of control of behaviour;

(i) "Minister" means the Minister of Social Services and Community Health;

(j) "nearest relative" means,

(i) with respect to a formal patient, the person first listed in the following paragraphs, relatives of the whole blood being

preferred to relatives of the same description of the half-blood and the elder or eldest of 2 or more relatives described in any paragraph being preferred to the other of those relatives regardless of sex:

(A) husband or wife,

(B) son or daughter,

(C) father or mother,

(D) brother or sister,

(E) grandfather or grandmother,

(F) grandson or granddaughter,

(G) uncle or aunt,

(H) nephew or niece,

or, if the formal patient is a ward of the Crown under the *Child Welfare Act*, it means the Minister of Social Services and Community Health,

but

(ii) when

(A) there is no nearest relative within any description in subclause (i), or

(B) in the opinion of the board the nearest relative determined under subclause (i) would not act or is not acting in the best interests of a formal patient,

it means any person the board designates in writing to act as the nearest relative;

(k) "patient" means

(i) a formal patient,

(ii) a person detained pursuant to a warrant of the Lieutenant Governor in Council, and

(iii) a person remanded to a facility pursuant to the *Criminal Code* (Canada);

(l) "prescribed" means prescribed in the regulations;

(m) "renewal certificate" means a certificate issued pursuant to section 20;

(n) "review panel" means a review panel established pursuant to section 7;

(o) "solicitor" means a member of The Law Society of Alberta.

1972 c118 s1;1973 c76 s2;1975(2) c12 s8; 1975(2) c26 s82(1);1976 c63 s84;1979 c50 s6

PART 1

GENERAL

Director and staff

2(1) In accordance with the *Public Service Act* there may be appointed a Director of Mental Health Services and an Associate Director of Mental Health Services and any other employees required for the purposes of this Act.

(2) The powers and duties conferred or imposed on the Director by this Act or the regulations may be exercised or performed by the Associate Director or any other person designated by the Minister.

1972 c118 s2

Operation of facilities

3(1) The Minister may establish and operate places for the observation, examination, care, treatment, control and detention of persons suffering from mental disorder.

(2) The Minister, with the approval of the Lieutenant Governor in Council, may enter into agreements with appropriate authorities of the Government of Canada or of any province or territory in Canada for the reception, observation, examination, care, treatment and detention in a facility in Alberta of persons suffering from mental disorder.

1972 c118 s3

Delegation of powers and duties

4 A board may delegate to any employee on the staff of the facility any of its powers and duties under this Act or the regulations.

1972 c118 s4

Provincial Mental Health Advisory Council

5(1) There is hereby established a Provincial Mental Health Advisory Council consisting of

(a) one person nominated by the College of Physicians and Surgeons of the Province of Alberta,

(b) one person nominated by the Alberta Association of Registered Nurses,

(c) one person nominated by the Alberta Association of Social Workers,

(d) one person nominated by The Alberta Medical Association (C.M.A. - Alberta Division),

(e) one person nominated by the Psychiatric Nurses Association of Alberta,

(f) one person nominated by the Psychologists Association of Alberta,

(g) one person nominated by the Alberta Psychiatric Association,

(h) one person nominated by the Alberta Hospitals Association,

(i) 2 persons nominated by the Canadian Mental Health Association,

(j) one person nominated by The Governors of The University of Alberta,

(k) one person nominated by The Governors of The University of Calgary,

(l) one person nominated by the Minister of Hospitals and Medical Care,

(m) one person nominated by The Law Society of Alberta,

(n) the Director of Mental Health Services,

(o) 2 persons representative of the general public, and

(p) not more than 3 other persons,

and appointed by the Lieutenant Governor in Council.

(2) Notwithstanding subsection (1), each member of the Council may appoint in writing a person to be an alternate member of the Council to act in his stead as a member of the Council in the event of his absence or inability to act.

(3) The Lieutenant Governor in Council shall designate the chairman of the Council.

(4) The Council may make rules governing the calling of its meetings, the conduct of its meetings and any other matter pertaining to the conduct of its business and affairs.

(5) A majority of the members of the Council or their respective alternate members constitutes a quorum.

(6) The members of the Council hold office during pleasure unless the appointment is expressed to be for a particular period of time.

(7) The Council, in addition to its other duties and functions specified in this Act

(a) shall inquire into any matter referred to it by the Minister;

(b) may inquire into and consider any matter pertaining to mental health;

(c) may review any policies, programs, services or administrative procedures of departments of the Government or of Government agencies in matters pertaining to mental health;

(d) may advise on the planning, development, standards, co-ordination and evaluation of mental health services in Alberta,

and report, and when appropriate make recommendations, to the Lieutenant Governor in Council.

(8) Any secretarial or clerical assistance that the Council requires shall be supplied by the Director of Mental Health Services.

1972 c118 s5;1977 c62 s12;1977 c93 s4(2)

Regional mental health areas

6(1) The Lieutenant Governor in Council may, by regulation, establish areas within Alberta as regional mental health areas.

(2) When a regional mental health area is proposed to be or has been established, the Lieutenant Governor in Council may establish a Regional Mental Health Council for that area.

(3) The Minister shall appoint members to a Regional Mental Health Council in accordance with the regulations.

(4) The Regional Mental Health Council shall advise any person, agency, organization or other body on any aspect of mental health that it considers necessary or desirable.

(5) A Regional Mental Health Council has the powers, duties and functions given to it by the regulations.

1972 c118 s18

Review panel

7(1) The Minister shall establish one or more review panels for the purpose of hearing and considering applications from formal patients concerning the cancellation of admission certificates or renewal certificates.

(2) Each review panel shall be appointed by the Minister and composed of

(a) a psychiatrist,

(b) a physician,

(c) a solicitor, who shall be chairman, and

(d) a person representative of the general public.

(3) The Minister may designate a vice-chairman of the review panel and may appoint one or more alternate members in accordance with subsection (2) and if for any reason a member of a review panel

cannot act he shall be replaced by an appropriate alternate member who shall act until the hearing is complete, and when so acting, an alternate member is a member for all purposes.

1972 c118 s19;1976 c63 s84;1979 c50 s7

Membership of review panel

8(1) A quorum for a review panel is the 4 members or alternate members appointed pursuant to section 7.

(2) Each member of the review panel is entitled to one vote, and in the event of a tie vote, the member acting as chairman has a 2nd vote.

(3) A decision of a majority of the members is the decision of the review panel.

(4) The Minister may periodically review the appointment of the members and alternate members to review panels and make any changes he considers advisable.

1972 c118 s20

Persons prohibited as members on review panel

9(1) No person who is actively serving as a member of the staff of a facility is eligible to sit as a member or alternate member of a review panel when the panel is considering an application from a formal patient of the facility with which he is connected.

(2) A person who is

(a) related by blood or marriage to a person applying to a review panel,

(b) a psychiatrist or physician who is treating or who has treated a person applying to a review panel, or

(c) a solicitor who is acting or who has acted for a person applying to a review panel,

is not eligible to be appointed as, or to sit as, a member or alternate member of a review panel for an application by that person.

1972 c118 s21;1979 c50 s2

Hearing by review panel

10(1) A review panel shall hear and consider applications in accordance with this Act and the regulations and for that purpose the members of the review panel have all the powers of a commissioner appointed under the *Public Inquiries Act*.

(2) The Minister shall provide secretarial, legal, consultative and other assistance to each review panel as may be required.

1972 c118 s22

PART 2

ADMISSION TO A FACILITY

Hospital authority unrestricted by Part 2

11 Nothing in this Part abrogates or restricts the authority conferred on a board by the *Hospitals Act* or any other Act.

1973 c76 s3

Refusal of admission to facility

12 When any person is refused admission to a facility, the board shall inform the person refused admission and if possible the referring source, of the reasons for the refusal and may refer the person to another facility or service, in which case the referring source, if any, shall be informed of any alternative arrangements made.

1972 c118 s23

Treatment and security of patient

13(1) On the admission of a patient to a facility a board is under a duty to provide the diagnostic and treatment services the patient is in need of and that the staff of the facility is capable and able to provide.

(2) The board of a facility in which a patient is detained shall determine what level of security is reasonably required for each patient in view of all the circumstances and thereafter is under a duty to provide it and to review the necessary level of security at intervals of not more than 6 months.

1972 c118 s24

Issue of conveyance and examination certificate

14 When a physician examines a person and is of the opinion that the person is

(a) suffering from mental disorder, and

(b) in a condition presenting a danger to himself or others,

he may, not later than 72 hours after the examination, issue a conveyance and examination certificate in the prescribed form with respect to the person.

1972 c118 s25;1979 c50 s7

Effect of conveyance and examination certificate

15(1) A conveyance and examination certificate is sufficient authority

(a) for any person to convey the person named in the certificate to a facility within 72 hours of the time it is issued and to detain that person while he is being so conveyed until the time he arrives at the facility, and

(b) for any physician to prescribe treatment for or to treat the person named in the certificate while he is being so conveyed and until the time he arrives at the facility.

(2) When a person is conveyed to a facility pursuant to a conveyance and examination certificate, the conveyance and examination certificate is sufficient authority

(a) for one or more physicians who are members of the staff of the facility to observe and examine the person named in the certificate,

(b) to provide any treatment that in the opinion of the physician may be essential for the well-being of the person named in the certificate, and

(c) to care for, detain and control the person named in the certificate,

for a period of 24 hours from the time that person arrives at the facility.

1972 c18 s26;1973 c76 s4;1979 c50 s3

Contents of conveyance and examination certificate

16 A conveyance and examination certificate shall show

(a) the name of the physician issuing it,

(b) the date and time the personal examination was conducted,

(c) the facts on which the physician formed his opinion that the person

(i) was suffering from mental disorder, and

(ii) was in a condition presenting a danger to himself or others,

distinguishing the facts observed by him from the facts communicated to him by others, and

(d) the date and time of issue.

1972 c118 s27;1979 c50 s4

Examination of person detained

17(1) A person detained in a facility pursuant to a conveyance and examination certificate shall be examined as soon as possible.

(2) When a person is detained under

(a) a conveyance and examination certificate, or

(b) one admission certificate,

that person shall be released on the expiry of 24 hours from the time that the person arrived at the facility unless there are, within that time, 2 admission certificates in effect with respect to that person.

1972 c118 s28;1975(2) c65 s2

Formal Admission

Admission certificate

18(1) When 2 physicians, after separate examinations by each of them, are of the opinion that a person is

(a) suffering from mental disorder,

(b) in a condition presenting a danger to himself or others, and

(c) unsuitable for admission to a facility other than as a formal patient,

each shall issue an admission certificate in the prescribed form.

(2) In any case where at least one of the examinations conducted under subsection (1) does not take place at the facility to which the person examined is intended to be admitted as a formal patient, that person shall not be admitted as a formal patient at that facility unless at least one of the admission certificates is issued by a member of the staff of that facility.

(3) An admission certificate shall show

(a) the name of the physician issuing it,

(b) the date and time the personal examination was conducted,

(c) the facts on which the physician formed his opinion that the person

(i) was suffering from mental disorder, and

(ii) was in a condition presenting a danger to himself or others,

distinguishing the facts observed by him from the facts communicated to him by others, and

(d) the date and time of issue.

1972 c118 s29;1973 c76 s5;1979 c50 s6

Effect of admission certificate

19(1) Two admission certificates are sufficient authority to observe, examine, care for, treat, control and detain the person named in them, in a facility, for a period of one month from the date the 2nd admission certificate is issued.

(2) One admission certificate has the same effect and provides the same authority as a conveyance and examination certificate issued under section 15.

1972 c118 s30;1973 c76 s6;1975(2) c65 s3

Renewal certificates

20(1) The period of detention of a formal patient may be extended when 2 physicians, after separate examinations by each of them, are of the opinion that the formal patient is

(a) suffering from mental disorder,

(b) in a condition presenting a danger to himself or others, and

(c) unsuitable for continuation at the facility other than as a formal patient,

and each issues a renewal certificate in the prescribed form.

(2) At least one of the persons who issues a renewal certificate under this section shall be a member of the staff of the facility where the examination was made.

(3) Two renewal certificates are sufficient authority to observe, examine, care for, treat, control and detain the person named in them

(a) in the first case where 2 renewal certificates are issued, for a period of not more than 2 additional months;

(b) in the 2nd case and each subsequent case where 2 renewal certificates are issued, for a period of not more than 6 additional months.

(4) A formal patient whose period of detention under admission certificates or renewal certificates expires is thereupon a voluntary patient not subject to detention and shall be informed of that fact.

(5) A formal patient whose authorized period of detention under admission certificates or renewal certificates has not expired may be continued as a voluntary patient in accordance with the by-laws of the board and thereupon the admission certificates or renewal certificates, as the case may be, shall be deemed to be cancelled.

1972 c118 s31;1973 c76 s7;1979 c50 s6

Contents of renewal certificate

21 A renewal certificate shall show

(a) the name of the physician issuing it,

(b) the date that the personal examination was conducted,

(c) the facts on which the physician formed his opinion that the person

(i) was suffering from mental disorder, and

(ii) was in a condition presenting a danger to himself or others,

distinguishing the facts observed by him from the facts communicated to him by others, and

(d) the date of issue.

1972 c118 s32;1979 c50 s6

Warrant for apprehension

22(1) Anyone who has reasonable and probable grounds to believe that a person

(a) may be suffering from mental disorder, and

(b) is in a condition presenting a danger to himself or others

may bring an information under oath before a provincial judge.

(2) When an information is brought before a provincial judge under subsection (1) and the judge is satisfied that

(a) the person with respect to whom the information is brought should be examined in the interests of his own safety or the safety of others, and

(b) an examination can be arranged in no other way,

he may issue a warrant to apprehend that person for an examination.

(3) A warrant under this section may be directed to all or any peace officers and shall name or otherwise describe the person with respect to whom the warrant is issued.

(4) If a peace officer apprehends a person pursuant to a warrant under this section, the person shall be deemed to be a person in respect of whom a conveyance and examination certificate has been issued.

1972 c118 s33;1977 c93 s4(4)

Peace officer's power

23(1) When a peace officer observes a person

(a) apparently suffering from mental disorder,

(b) in a condition presenting a danger to himself or others, and

(c) acting in a manner that in a normal person would be disorderly,

the peace officer may, if he is satisfied that

(d) the person should be examined in the interests of his own safety or the safety of others, and

(e) the circumstances are such that to proceed under section 22 would be dangerous,

convey the person to a facility for an examination.

(2) A person conveyed to a facility pursuant to subsection (1) shall be deemed to be a person in respect of whom a conveyance and examination certificate has been issued.

1972 c118 s34

PART 3

RIGHTS OF PATIENTS

Duties toward patient

24(1) On a person becoming

(a) a formal patient, or

(b) the subject of renewal certificates,

the formal patient and his nearest relative shall

(c) be informed of the reason for his admission or the issuance of renewal certificates in simple language, and

(d) be given a written statement of

(i) the authority for his detention and the period thereof,

(ii) the function of the review panels,

(iii) the name and address of the chairman of the appropriate review panel, and

(iv) his right to apply to the review panel for cancellation of the admission certificates or renewal certificates.

(2) In the event of language difficulty, the board shall obtain a suitable interpreter and provide the explanation and written statement referred to in subsection (1) in the language spoken by the formal patient or his nearest relative.

(3) In addition to giving an explanation and written statement pursuant to this section, the board shall, having regard to the circumstances in each case in which the formal patient desires to exercise his right to apply for cancellation of admission certificates or renewal certificates, do any other things the board considers expedient to facilitate the submission of one or more applications.

1972 c118 s36;1976 c63 s84

Proceedings of Review Panels

Application to review panel

25(1) A formal patient or a person on his behalf may apply to a review panel for cancellation of

(a) admission certificates, or

(b) renewal certificates,

by sending notice of application to the chairman of the appropriate review panel in the prescribed form.

(2) The Minister, the Director or a board may submit an application

under subsection (1) on behalf of a formal patient, but when an application is so made, the word "applicant" wherever it occurs in this Part and section 47(1) includes the formal patient but not the Minister, the Director or the board.

(3) Only one application may be made to a review panel by a formal patient or a person on his behalf with respect to each 2 admission certificates or renewal certificates issued, but the Minister, the Director or a board may apply at any time.

1972 c118 s38;1976 c63 s84

Notice of hearing

26(1) On receipt of an application under section 25, the chairman of a review shall give notice

(a) to the applicant and any person acting on his behalf, and

(b) to the nearest relative and any other person that the chairman considers may be affected by the application and should be notified,

of the date, time, place and purpose of the hearing.

(2) As soon as it is able to do so, the review panel shall carry out whatever investigation and hearing it considers necessary and may invite the applicant and any other person to testify or produce evidence at the hearing.

1972 c118 s39;1976 c63 s84

Privacy of review panel proceedings

27(1) All proceedings of a review panel shall be conducted in private and subject to subsection (2) no person has a right to be present without the prior consent of the chairman.

(2) The applicant and his representative have the right to be personally present during the presentation of any evidence to the review panel, but if in the opinion of the review panel there may be an adverse effect on the applicant's health by his presence, the applicant may be excluded, but in that event the review panel shall appoint a person to act on his behalf if he does not already have a representative.

(3) The applicant or person acting on his behalf has the right of cross-examination.

(4) Except as permitted by the chairman and except when the report is published by the applicant or his representative, no person shall publish a report of a hearing, investigation or deliberation by a review panel or the names of any persons concerned therewith.

(5) The chairman may adjourn a hearing for any period up to 21 days (and with consent of the Minister for a longer period) for any purpose he considers necessary.

1972 c118 s40;1973 c76 s10

Hearing by review panel

28(1) Within 28 days of the receipt of an application by the chairman

or any longer period the Minister allows, the review panel shall hear and consider an application.

(2) When the application is for the cancellation of admission certificates or renewal certificates, the review panel may

(a) cancel the admission certificates or renewal certificates, as the case may be, with or without conditions, if it considers that the applicant is not in a condition presenting a danger to himself or others, or

(b) refuse to cancel the admission certificates or renewal certificates.

(3) The chairman of the review panel shall send a copy of the decision of the review panel in writing to the applicant, his nearest relative and to any person interested in the application, within 7 days of the date of its decision.

(4) When the review panel refuses to cancel admission certificates or renewal certificates, the written report of the decision of the review panel shall include a statement of the right of the applicant to appeal the decision of the review panel to the Court of Queen's Bench under section 32.

(5) When the application to the review panel was made by the Minister, the Director or a board, the chairman of the review panel shall send a copy of the report to the applicant and to the Minister, the Director or the board, as the case may be.

(6) The board of the facility in which the formal patient is detained shall take whatever action may be required to give effect to the decision of the review panel.

1972 c118 s41;1978 c51 s28

Return to correctional institution

29(1) When a person is convicted of a criminal offence and is sent to a facility for treatment, that person, whether or not admission certificates or renewal certificates have been issued with respect to him, may apply to the review panel in accordance with section 25 for an order transferring him back to a correctional institution.

(2) A review panel hearing an application under subsection (1) may

(a) make the order applied for, or

(b) cancel the admission certificates or renewal certificates.

(3) When a review panel makes an order transferring a person from a facility to a correctional institution or cancels admission certificates or renewal certificates, the board of the facility in which the person is detained shall

(a) comply with the order, or

(b) when admission certificates or renewal certificates are cancelled, arrange to have the person returned to a correctional institution.

1972 c118 s42

Communications and Visitors

Communications by and to patient

30 No communication written by a patient in a facility or to a patient in a facility shall be opened, examined or withheld and its delivery shall not in any way be obstructed or delayed by the board or a member of the staff at a facility.

1972 c118 s44

Visiting hours

31(1) A patient shall not be prevented from receiving visitors at hours fixed by the board unless a physician considers that a visitor would be detrimental to the patient's health.

(2) Notwithstanding subsection (1), a solicitor acting for a patient may visit the patient at any time.

1972 c118 s45;1973 c76 s11;1979 c50 s7

Appeal to Court of Queen's Bench

Appeal

32(1) Within 14 days of a decision of a review panel, the applicant may appeal to the Court of Queen's Bench.

(2) The application shall be made by originating notice.

(3) The notice shall be served on

(a) the Minister,

(b) the chairman of the board of the facility in which the applicant is a formal patient (if the applicant is a formal patient), and

(c) any other persons the Court directs,

not less than 15 days before the motion is returnable and the practice and procedure of the Court pertaining to applications by originating notice applies, so far as it is applicable, to an application under this section, except as otherwise provided by this section.

(4) The application shall be supported by an affidavit of the applicant setting forth fully all the facts in support of the application.

(5) An appeal under this section shall be a rehearing of the matter on the merits, and in addition to any further evidence adduced by the applicant, the Minister or the Public Trustee, the Court may direct that any transcript or minutes taken by the review panel at the original hearing of the evidence be put in evidence on the appeal

and may direct that further evidence be given as it considers necessary.

(6) An order of the Court under this section is not subject to appeal.

(7) The Court may make whatever order as to the costs of the application that it considers fit.

(8) The Court may, with respect to an appeal from a decision of a review panel to refuse to cancel admission certificates or renewal certificates,

(a) quash the decision and order the cancellation of the admission certificates or renewal certificates, as the case may be,

(b) order that the review panel reconsider the applicant's application for cancellation, or

(c) make any other order it considers just.

1972 c118 s46;1975(2) c65 s7;1976 c63 s84;1978 c51 s28

Discharge

Discharge from facility

33(1) When a formal patient is discharged from a facility, the board shall, where possible, give notice of the discharge

(a) to the nearest relative, if the person discharged agrees, and

(b) to the referring source,

and when applicable shall state in the notice whether a certificate of incapacity issued under the *Dependent Adults Act* exists with respect to the person.

(2) When a formal patient has been discharged and refuses or is unwilling to leave the facility, the board or a representative of the board may require that the removal of the former patient be effected by

(a) any person who is liable for the payment of expenses incurred with respect to the former patient pursuant to section 45(1), or

(b) the Minister of Social Services and Community Health.

(3) The board may by registered mail notify the person responsible for the removal of the former patient to remove the former patient within 10 days from the receipt of the notice.

(4) If the notice is given under subsection (3), a copy of the notice shall be given by mail to the Director.

(5) When the notice under subsection (3) is given to a person referred to in subsection (2)(a) and that person fails to comply with the notice,

that person is guilty of an offence and liable to a fine of not more than $50 and in default of payment to imprisonment for a term not exceeding 10 days.

1972 c118 s47;1973 c76 s12;1975(2) c12 s8;1976 c63 s84

Treatment after discharge

34(1) A board shall comply with and take any necessary action to comply with a decision of a review panel concerning admission certificates or renewal certificates.

(2) An order of cancellation of admission certificates or renewal certificates does not require a board to cease treatment of a person if that person wishes to receive treatment on a voluntary basis and the board is willing and able to provide the treatment.

(3) When a formal patient is no longer a danger to himself or others, he may be discharged by the board and thereupon the admission certificates or renewal certificates, as the case may be, shall be deemed to be cancelled.

1972 c118 s48;1973 c76 s13

Examination and Detention at a Facility Pursuant to an Order of Court

Out-patients

35(1) When a judge has reason to believe that a person who appears before him charged with or convicted of an offence, suffers from mental disorder, the judge may order the person to attend a facility or service as an out-patient for examination.

(2) When an examination is made under this section, a report in writing shall be made to the judge as to the mental condition of the person.

(3) If the report indicates that the person examined needs treatment, the judge may order the person to attend a facility or service for treatment as an out-patient.

1972 c118 s49

Remand to facility for examination

36(1) A person who, pursuant to the *Criminal Code* (Canada), is remanded to custody for observation may be admitted to, examined and detained in and discharged from a facility in accordance with the law.

(2) A person who, pursuant to the *Criminal Code* (Canada), is detained under the authority of a warrant of the Lieutenant Governor may be admitted to, examined, treated and detained in and discharged from a facility in accordance with the law.

1972 c118 s50

Confidentiality of diagnoses, records, etc.

37(1) In this section,

(a) "diagnostic and treatment centre" or "centre" means a place established by the Minister pursuant to section 3(1) and

includes a facility that is not an approved hospital under the *Hospitals Act;*

(b) "legal representative" means an executor or administrator of the estate of a deceased person, the guardian or trustee of a dependent adult under the *Dependent Adults Act* or the guardian of a person who is a minor.

(2) The Minister shall cause a record to be kept of the diagnostic and treatment services provided to every person in a diagnostic and treatment centre.

(3) For the purposes of assessing the standards of care furnished to persons in a diagnostic and treatment centre, improving mental health care facilities or procedures or for any other purpose considered by the Minister to be in the public interest, the Minister or any person authorized by the Minister may require that all or any of the following be sent to the Minister or any person designated by the Minister:

(a) medical and other records in a centre;

(b) extracts from and copies of those records;

(c) diagnoses, charts or information available in respect of any person receiving diagnostic and treatment services in a centre.

(4) Information obtained from records maintained in a diagnostic and treatment centre or from persons having access thereto shall be treated as private and confidential information in respect of the person receiving diagnostic and treatment services in the centre and shall be used solely for the purposes described in subsection (3), and the information shall not be published, released or disclosed in any manner that would be detrimental to the personal interest, reputation or privacy of that person or that person's attending physician.

(5) Any person who knowingly and wilfully releases or discloses information described in subsection (4) to a person not authorized to receive it is guilty of an offence and is liable to a fine of not more than $500.

(6) Notwithstanding subsection (4) or any other law, the Minister, a person authorized by the Minister or a physician may disclose any diagnosis, record or information relating to a person receiving diagnostic and treatment services in a centre

(a) to the person to whom the diagnosis, record or information relates or his legal representative,

(b) with the written consent of the person to whom the diagnosis, record or information relates, to any person, if in the opinion of the person making the disclosure it is in the best interests of the person to whom the diagnosis, record or information relates to disclose that information,

(c) to a department or agency of the Government or a physician if that department, agency or physician is responsible for providing continued treatment to the person to whom the diagnosis, record or information relates,

(d) to the Public Guardian, as defined in the *Dependent Adults Act*, if the diagnosis, record or information is, in the opinion of the person making the disclosure, relevant to the making of a guardianship order or a trusteeship order under the *Dependent Adults Act* in respect of the person to whom the diagnosis, record or information relates,

(e) to a review panel established pursuant to section 7 that is to hear or is hearing an application from the person to whom the diagnosis, record or information relates,

(f) to a department or agency of the Government when the disclosure is necessary in the administration of this Act or in the best interests of the person to whom the diagnosis, record or information relates,

(g) to a person conducting bona fide research or medical review if the disclosure is made in such manner as to ensure confidentiality of the diagnosis, record or information,

(h) to the Director of Medical Services under the *Occupational Health and Safety Act* when the diagnosis, record or information relates to an accident that occurred in respect of the person's occupation or one or more of his former occupations, or to a disease which is related to the person's occupation or one or more of his former occupations,

(i) to a Workers' Compensation Board, the Alberta Hospital Association or a provincial hospital insurance authority, if the information is required in order to establish its liability for payment,

(j) to the Department of National Health and Welfare for purposes in connection with the *Medical Care Act* (Canada) or the *Hospital Insurance and Diagnostic Services Act* (Canada),

(k) to a medical records school for training purposes if the disclosure is made in such a manner that individual names of the person to whom the records relate are not revealed or made identifiable,

(l) to a board of review appointed pursuant to the *Criminal Code* (Canada) that is to review the case of the person to whom the diagnosis, record or information relates, or

(m) to the council of the College of Physicians and Surgeons of the Province of Alberta or an investigating committee under the *Medical Profession Act*, if

(i) an officer of the College makes a written request for the diagnosis, record or information and the disclosure is consented to by the person to whom the diagnosis, record or information relates or his legal representative, or

(ii) the disclosure is made in compliance with a notice under section 49 of the *Medical Profession Act*, to attend as a witness or to produce documents.

(7) Notwithstanding subsection (4) or any other law, a medical examiner appointed under the *Fatality Inquiries Act* is entitled to inspect and make copies of any diagnosis, record or information relating to a person receiving diagnostic and treatment services in a centre.

(8) Where a medical examiner obtains a copy of any diagnosis, record or information pursuant to subsection (7), the provincial judge who presides at a public inquiry under the *Fatality Inquiries Act* may admit the copy of the diagnosis, record or information in evidence at the public inquiry but all proceedings related to the diagnosis, record or information shall be in private.

(9) Notwithstanding subsection (4) or any other law, when the Minister, a person authorized by the Minister or a physician

(a) is unable to disclose any diagnosis, record or information relating to a person by reason of subsection (4), or

(b) refuses to disclose any diagnosis, record or information relating to a person pursuant to subsection (6),

the person or his legal representative may apply to the court for an order directing the person having the diagnoses, records or information to release them or a copy of them to the person to whom the information relates or his legal representative or to some other person named in the order.

(10) An application under subsection (9) shall be made

(a) on motion in the course of any action or proceedings to which the person to whom the diagnosis, record or information relates or his legal representative is a party, to a judge of the court in which the action or proceedings is taken, or

(b) by way of originating notice to the Court of Queen's Bench, in any other case.

(11) An application under subsection (9) shall be heard in private and on the hearing of the motion the onus of showing why the order should not be made for the release of the diagnosis, record or information, or a copy of it, is on the respondent to the motion.

1976 c72 s2;1976 c63 s84;1976 c66 s57;1977 c93 s4(5);1978 c51 s38(42);1979 c50 s5

PART 4

ADMINISTRATIVE

Leave of absence

38(1) Notwithstanding any admission certificates or renewal certificates issued with respect to a formal patient, the medical director of a facility may grant a formal patient leave of absence from a facility.

(2) Leave of absence may be granted on any terms and conditions prescribed by the medical director and without restricting the generality of the foregoing may include a condition that the formal patient remain under the supervision and subject to the treatment of any person or persons authorized by the medical director.

(3) When a formal patient is on a leave of absence granted under this section and it appears to the medical director that the patient's condition is presenting a renewed danger to himself or others, the board may by notice in writing given to

(a) the formal patient, or

(b) the person supervising the patient,

revoke the leave of absence and recall the formal patient to the facility.

(4) When a formal patient refuses to return to the facility or when the medical director is unable to serve a notice in writing pursuant to subsection (3), the medical director may declare the formal patient to be absent without leave and order any peace officer to return the person to the facility.

(5) Nothing in this section authorizes the granting of a leave of absence to a formal patient who is

(a) detained pursuant to a warrant of the Lieutenant Governor, or

(b) remanded to a facility pursuant to the *Criminal Code* (Canada).

1972 c118 s51;1975(2) c65 s8

Transfer to another facility

39(1) A board may, if otherwise permitted by law and subject to arrangements being made with another board, transfer a patient to the other facility on completing a memorandum of transfer in the prescribed form.

(2) When a patient is transferred under subsection (1), the authority to detain him continues in force in the facility to which he is transferred.

1972 c118 s52

Hospital treatment

40(1) When a patient requires hospital treatment that cannot be

supplied in the facility, the board may, if otherwise permitted by law, transfer the patient to a hospital for treatment and return him to the facility on the conclusion of the treatment.

(2) When a patient is transferred under subsection (1), the board of the hospital or a person designated by it has, in addition to the powers conferred on it by any other Act, the powers under this Act of a board in respect of the custody, control and treatment of the patient.

1972 c118 s53

Transfer into Alberta

41 When the Director has reason to believe that a person suffering from mental disorder may come or be brought into Alberta, the Director may issue a certificate in the prescribed form and a conveyance and examination certificate shall be deemed to have been issued at the time that person comes or is brought into Alberta.

1972 c118 s54

Transfer out of Alberta

42 When it appears to the Director

(a) that a formal patient has come or been brought into Alberta and his observation, care and treatment is the responsibility of another jurisdiction, or

(b) that it would be in the best interests of a formal patient to be cared for in another jurisdiction,

the Director may, on compliance in Alberta with the laws of the other jurisdiction, with all necessary modifications, issue a transfer in the prescribed form, to authorize his transfer to the other jurisdiction.

1972 c118 s55

Absence without leave

43(1) When a formal patient leaves a facility and leave of absence has not been granted, the board may order any peace officer to return the person to the facility.

(2) On receipt of

(a) an order pursuant to subsection (1), or

(b) an order pursuant to section 38(4)

every peace officer is empowered to arrest, without warrant, the person named in the order and return that person to the facility.

(3) For the purposes of this Act, a formal patient who is returned to a facility under this section or section 38 may be detained for the remainder of the authorized period of detention to which he was subject when his absence was discovered.

1972 c118 s56;1975(2) c65 s9

Validity of documents

44 A conveyance and examination certificate, an admission certificate, renewal certificate, warrant, certificate, order, transfer or other form issued under this Act or the regulations shall not be held to be

insufficient or invalid by reason only of any irregularity, informality or insufficiency in it or in any proceedings in connection with it.

1972 c118 s57;1976 c63 s84

Liability for maintenance charges

45(1) Section 46 of the *Hospitals Act* applies, with all necessary modifications, with respect to facilities, and the person liable for the payment of charges under that section is liable for the payment of the expenses incurred in connection with the examination, admission, detention, conveyance, care and maintenance of a patient.

(2) When a person is admitted to and detained in a facility on the authority of a warrant of the Lieutenant Governor under the *Criminal Code* (Canada), the expenses incurred after the making of the order shall be paid by the person who would be liable under subsection (1) if the person had been admitted under the authority of this Act, except that when the person is under a sentence of imprisonment the expenses incurred during the term of the imprisonment shall be paid by the Government.

(3) When the person liable for the payment of the expenses under subsection (1) or (2) is not possessed of sufficient means to pay the expenses, the expenses shall be paid by the Government.

1972 c118 s58

Recovery of expenses

46(1) All expenses incurred in connection with the examination, admission, detention, conveyance, care and maintenance of any person under this Act shall be paid in the first instance by the Government.

(2) The Government may recover the expenses paid by it from the person liable for payment under section 45.

1972 c118 s59;1975(2) c65 s10

Regulations

47(1) The Lieutenant Governor in Council may make regulations with respect to the submission of applications to review panels and with respect to hearings, consideration and investigations of review panels and matters incidental thereto and consequential thereon and, without limiting the generality of the foregoing, may make regulations

(a) for regulating the methods by which information relevant to an application may be obtained by or furnished to a review panel and concerning visits and interviews of applicants in private;

(b) for regulating the circumstances in which and the persons by whom applicants may, if not desiring to conduct their own case, be represented;

(c) for making available to any applicant copies of any documents obtained by or furnished to the review panel in connection with the application and a statement of the substance of any oral information so obtained or furnished except where the review panel considers undesirable in the interests of the applicant, or for other special reasons, that this be done;

(d) conferring ancillary functions on review panels.

(2) The Lieutenant Governor in Council may make regulations

(a) designating any place or part of a place as a facility;

(b) classifying facilities for any purpose;

(c) in respect of facilities or any class of facilities,

(i) providing for the creation, establishment, construction, alteration, renovation and maintenance of them,

(ii) prescribing the accommodation, equipment, conduct, operations, use and control of them,

(iii) providing for the government, management, conduct, operation, use and control of them,

(iv) providing for the officers and staff and prescribing their qualifications,

(v) prescribing the forms, records, books, returns and reports to be made and kept in connection with them and providing for returns, reports and information to be furnished to the Minister,

(vi) prescribing the charges that the owner or operator of a facility or any class of facility may make for diagnostic and treatment services and other services provided to persons who are not patients and who are not entitled to those services at the expense of the Government, and

(vii) prescribing the charges that the owner or operator of a facility or any class of facility may make for diagnostic and treatment services and other services provided to patients in that facility who are not entitled to those services at the expense of the Government;

(d) prescribing the classes of grants by way of Government aid to any facility or class of facility and the methods of determining the amounts of grants and providing for the manner and times of payment and the suspension and withholding of grants and for the making of deductions from grants;

(e) classifying patients and limiting the classes of patients that may be admitted to any facility or class of facility;

(f) respecting the examination and detention of persons and the admission, detention, leave of absence, absence without leave, transfer, discharge and placement of patients;

(g) prescribing forms and providing for their use;

(h) establishing regional mental health areas;

(i) establishing Regional Mental Health Councils for or for proposed regional mental health areas;

(j) concerning the composition of, numbers or criteria for appointing members to one or more Regional Mental Health Councils;

(k) governing the powers, duties and functions of a Regional Mental Health Council;

(l) prescribing the remuneration and expenses to be paid to members of the registration board, the members and alternate members of the Provincial Mental Health Advisory Council, members and alternate members of Regional Mental Health Councils and the members and alternate members of review panels;

(m) respecting any matter necessary or advisable to carry out effectively the intent and purpose of this Act.

(3) If the Lieutenant Governor in Council designates any place as a facility, he may by regulation

(a) limit or restrict the purposes under this Act or the regulations for which that place is designated as a facility;

(b) make inapplicable to a facility or any class of facility any of the provisions of this Act.

1972 c118 s60;1973 c76 s14;1975(2) c65 s11;1977 c93 s4(6)

MENTAL HEALTH ACT

CHAPTER M-13

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GOVERNMENT OF THE PROVINCE OF ALBERTA

MENTAL HEALTH AMENDMENT ACT, 1981

(Assented to December 2, 1981)

CHAPTER 72

1981

As revised pursuant to section 6 of
The Revised Statutes 1980 Act

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Dr. Reid

MENTAL HEALTH AMENDMENT ACT, 1981

CHAPTER 72

(Assented to December 2, 1981)

HER MAJESTY, by and with the advice and consent of the Legislative Assembly of Alberta, enacts as follows:

RSA 1980, cM-13

1 The Mental Health Act is amended by this Act.

2 Section 1(b) is amended by striking out "or" *at the end of subclause (i), by adding* "or" *at the end of subclause (ii) and by adding the following after subclause (ii):*

(iii) a Mental Health Hospital Board established under section 49;

3 Section 5 is amended

(a) in subsection (1)

(i) by repealing clause (a) and substituting the following:

(a) one member jointly nominated by the College of Physicians and Surgeons of the Province of Alberta and The Alberta Medical Association (C.M.A. - Alberta Division),

(ii) by repealing clauses (d), (l) and (o):

(iii) by repealing clause (n) and substituting the following:

(n) one member of each Regional Mental Health Council,

(iv) in clause (p) by striking out "3 other persons" *and substituting* "4 other persons representative of the general public";

(b) by adding the following after subsection (1):

(1.1) The bodies referred to in subsection (1)(a) to (m) shall

(a) in the case of a body other than one referred to in subsection (1)(a) or (i), nominate at least 3 persons,

(b) in the case of the bodies referred to in subsection (1)(a), jointly nominate at least 3 persons, and

(c) in the case of the body referred to in subsection (1)(i), nominate at least 6 persons.

(c) by repealing subsection (2) and substituting the following:

(2) The Lieutenant Governor in Council may appoint alternate members of the Council to act in the absence of the members appointed under subsection (1).

(2.1) A member or alternate member of the Council shall not vote in the Council on any matter in which he has a direct or indirect pecuniary interest.

(d) by adding the following after subsection (6):

(6.1) The Director of Mental Health, the Minister of Hospitals and Medical Care and the Minister of Advanced Education and Manpower or their representatives shall be given notice of and may attend all meetings of the Council.

4 *Section 6 is amended*

(a) by adding the following after subsection (3):

(3.1) A member of a Regional Mental Health Council shall not vote on any matter in which he has a direct or indirect pecuniary interest.

(b) by repealing subsection (4) and substituting the following:

(4) The Regional Mental Health Council shall advise the Provincial Mental Health Advisory Council on any aspect of mental health that the Regional Council considers necessary or desirable.

5 *Section 28(2) is amended*

(a) in clause (a) by striking out "with or without conditions,";

(b) in clause (b) by adding ", with or without conditions" *after* "renewal certificates".

6 *Section 37 is amended*

(a) in subsection (1)

(i) by renumbering clause (a) as clause (a.1) and by adding the following before clause (a.1):

(a) ''Board'' means a Mental Health Hospital Board established under section 49;

(ii) by adding the following after clause (b):

(c) ''mental health hospital'' has the meaning given to it in Part 5.

(b) by adding the following after subsection (2):

(2.1) The Board of a mental health hospital shall cause a record to be kept of the diagnostic and treatment services provided to every person in the mental health hospital.

(c) in subsection (6) by adding the words '', a Board or an employee of the Board'' *after* ''authorized by the Minister'';

(d) in subsection (9) by adding '', a Board or an employee of the Board'' *after* ''by the Minister''.

7 *The following is added after section 47:*

PART 5

MENTAL HEALTH HOSPITAL BOARDS

Definitions

48 In this Part,

(a) ''Board'' means a Mental Health Hospital Board established under section 49;

(b) ''mental health hospital'' means a hospital administered by a Board for the care and treatment of persons suffering from a mental disorder.

Establishment of Boards

49(1) The following Mental Health Hospital Boards are hereby established as corporations consisting of their respective members:

(a) The Mental Health Hospital Board, Ponoka;

(b) The Mental Health Hospital Board, Edmonton.

(2) The Mental Health Hospital Board, Ponoka, shall administer The Alberta Hospital, Ponoka.

(3) The Mental Health Hospital Board, Edmonton, shall administer The Alberta Hospital, Edmonton.

(4) Each Board shall consist of not more than 9 members appointed by the Lieutenant Governor in Council, each for a term of not more than 3 years.

(5) The Lieutenant Governor in Council shall designate 1 of the members of each Board to be chairman of the Board.

(6) The members of each Board shall elect 1 of its members as vice-chairman.

(7) No vacancy on a Board impairs the right of the remaining members to act while the vacancy exists.

(8) The vice-chairman shall act as chairman of a Board when the chairman is absent or when there is a vacancy in the office of chairman.

(9) A majority of the members of the Board constitutes a quorum at a meeting of a Board.

(10) An act or thing done by a majority of the members of the Board present at a meeting, if the members present constitute a quorum, shall be deemed to have been done by the Board.

(11) A by-law signed by a majority of the members of a Board is as valid and effective as if passed by a majority of the members present at a meeting at which a quorum was present.

(12) The members of a Board may be paid remuneration for their services and may be reimbursed for reasonable travelling and living expenses necessarily incurred by them in the performance of their duties at the rates prescribed by the Minister.

Board authority

50 Subject to any limitations of its authority imposed under this Act or any other Act, a Board has full control of the mental health hospital it administers and has absolute and final authority in respect of all matters pertaining to the operation of that hospital.

Board powers

51(1) A Board shall

(a) operate the mental health hospital under its administration for the observation, examination, care, treatment, control and detention of persons suffering from mental disorders;

(b) provide educational facilities to medical students, student nurses and other students of matters related to the care, treatment and prevention of mental disorders;

(c) provide the equipment necessary for the proper operation of the mental health hospital;

(d) employ necessary staff for the proper operation of the mental health hospital under its control including but not restricted to psychiatric, psychological, medical, surgical and

pharmaceutical officers, social workers, nurses and clerical staff;

(e) provide the necessary facilities for proper psychiatric, psychological and medical attendance, nursing, food and medicines;

(f) pay its employees the remuneration that it may determine.

(2) A Board may

(a) accept subscriptions, donations, devises and bequests, whether of real or personal property;

(b) sell, dispose of or otherwise realize any personal property of a Board;

(c) subject to the approval of the Minister, operate out-patient clinics for the diagnosis and treatment of mental disorders in conjunction with the mental health hospital under its administration and at other places in Alberta;

(d) delegate by by-law any of its powers or duties under this Act to any employee of the Board;

(e) do any other things that may be necessary for the operation of the mental health hospital under its administration.

(3) A Board shall, with the approval of the Minister, make by-laws governing the management, control and operation of the mental health hospital under its administration.

(4) The *Regulations Act* does not apply to any by-laws under this section or section 52.

Medical staff by-laws

52(1) A Board

(a) shall require the preparation and adoption of by-laws by its medical staff governing the organization and conduct of the physicians practising in the mental health hospital and the procedures whereby the medical staff shall make recommendations to the Board concerning the appointment, reappointment, termination or suspension of, appointment of, and the delineation of hospital privileges of, members of the medical staff,

(b) may from time to time require the amendment or repeal of the by-laws of the medical staff, and

(c) may approve or disapprove of those by-laws or amendments.

(2) On approval by a Board of the by-laws of the medical staff or any amendments as provided in subsection (1), the Board shall

send or cause to be sent a true copy of the by-laws or amendments signed by the appropriate officer of the medical staff and of the Board to the Minister for approval, and the by-laws or amendments are effective only on the written approval of the Minister.

(3) The by-laws of the medical staff shall make provision for

(a) the adoption of rules governing the day to day management of medical affairs in the mental health hospital and for the amendment or replacement of those rules from time to time as the need may arise, and shall provide that the rules become effective only on their approval by the hospital board;

(b) a procedure for the review of decisions made by the medical staff or the Board pertaining to or affecting the privileges of members of the medical staff;

(c) a procedure to ensure that all applications for appointment to medical staff reach the Board in the time prescribed in the by-laws, whether or not the appointment is recommended by the medical staff;

(d) a procedure whereby notice is to be given by the Board to an applicant for an appointment to the medical staff within a reasonable time of the decision of the Board as to whether or not his application has been accepted.

53(1) A copy of the minutes of each meeting of a Board shall be forwarded to the Minister.

(2) The Board shall provide the Minister with financial statements at the times and containing the information that he prescribes.

54(1) In each fiscal year a Board shall prepare its budget for the next following fiscal year.

(2) A budget prepared under subsection (1) shall be submitted to the Minister in the form and on or before the date prescribed by the Minister.

(3) If the Minister approves the budget of a Board for a fiscal year, he may, out of money voted by the Legislature for the purpose, pay grants to the Board in accordance with the regulations.

55(1) The Auditor General is the auditor of a Board.

(2) The fiscal year of a Board is the period commencing on April 1 in one year and ending on March 31 next following.

56(1) A Board shall, as soon as practicable after the end of each fiscal year, prepare and submit to the Minister a report sum-

marizing its transactions and affairs during the fiscal year just ended and containing its audited financial statement.

(2) When the report prepared under subsection (1) is received, the Minister shall lay a copy of it before the Legislative Assembly if it is then sitting and, if it is not then sitting, within 15 days after the commencement of the next ensuing sitting.

Borrowing power

57(1) A Board, with the approval of the Minister, may raise money required by the Board under this Act for construction, renovation or repair of the mental health hospital, and secure the money in any manner that the Board considers fit, and in particular by the issue of debentures or debenture stock, perpetual or otherwise, charged upon any or all of the Board's property, both present and future, and may purchase, redeem or pay off those securities.

(2) Notwithstanding section 16 of the *Interpretation Act*, a Board shall not sell or otherwise dispose of any of the real property of the Board unless it is authorized by the Minister to do so.

Medical staff appointment

58 A Board shall make all appointments to the medical staff of the mental health hospital.

Other staff

59 A Board shall, with the approval of the Minister, appoint an administrator and shall appoint or shall cause to be appointed, as the by-laws or regulations may require, any other officers and employees required for the efficient operation of the mental health hospital under its administration and shall prescribe their duties, remuneration and other terms of employment.

Medical staff responsibilities

60 The medical staff of each of the mental health hospitals is responsible

(a) to the Board for the clinical and scientific work of the mental health hospital and for advising the Board on all matters relating to patient care;

(b) to the Board for reviewing professional practices of the medical staff and other members of the treatment team at the mental health hospital;

(c) to the Board for the improvement of the care of patients in the mental health hospital;

(d) for making recommendations to the Board respecting utilization of the mental health hospital.

Medical staff review committee

61 A Board may appoint a committee called the "hospital medical staff review committee" to be responsible to the Board

(a) for evaluating and controlling clinical practice in the mental health hospital on a continuing basis for the purpose

of maintaining and improving the safety and quality of patient care, or

(b) for performing any functions in relation to the appraisal and control of the quality of patient care in the mental health hospital.

Appeal to Appeal Board

62 A member of the medical staff of a mental health hospital who considers himself aggrieved by a decision of a Board may appeal the decision to the Hospital Privileges Appeal Board in accordance with section 36 of the *Hospitals Act*, and sections 33 to 36 of that Act apply to the appeal.

Inquiries

63 The Minister and employees of the Government authorized by the Minister for the purpose may make all necessary inquiries into the management and affairs of the mental health hospitals, may visit and inspect mental health hospitals and may examine mental health hospital records for the purpose of verifying the accuracy of reports and ensuring that this Act and the regulations are being adhered to.

Investigation and mediation

64(1) If he is requested to do so by a Board, the Minister may authorize

(a) an investigation into the administration or operation of 1 or both of the mental health hospitals or any particular matter or problem that has arisen in connection with the administration or operation of the mental health hospital, or

(b) the mediation of any dispute that has arisen in the course of the administration or operation of 1 or both of the mental health hospitals.

(2) If the Minister has authorized an investigation or mediation proceedings pursuant to subsection (1), he may designate any or all of the following associations to form an investigation or mediation committee:

(a) the Alberta Hospital Association;

(b) the Alberta Association of Registered Nurses;

(c) The Alberta Medical Association (C.M.A. - Alberta Division);

(d) the Psychiatric Nurses Association of Alberta;

(e) The Psychologists Association of Alberta;

(f) The Alberta Association of Social Workers.

(3) The council or board of directors, as the case may be, of an association that is designated by the Minister under subsection (2) shall appoint 1 or more of the association's members to the

committee that is to conduct the investigation or mediation proceedings and shall inform the Minister accordingly.

(4) The committee consisting of the person or persons appointed pursuant to subsection (3)

(a) shall elect 1 of their number as chairman, if there are 2 or more members on the committee,

(b) shall conduct the investigation or mediation proceedings authorized by the Minister, and

(c) may require from a Board and its employees any information that the committee reasonably requires for the purpose of the investigation or mediation proceedings and is entitled to access to the relevant records of the Board for that purpose.

(5) Upon the completion of the investigation or mediation proceedings, the committee shall prepare a report on the proceedings and submit a copy of the report to the Board concerned, the Minister and the associations designated under subsection (2).

Public Inquiries Act

65(1) The Lieutenant Governor in Council may appoint a committee of inquiry to which, or to any member or members of which, a question respecting the conduct or management of a mental health hospital may be referred for the purpose of making an inquiry into the affairs of the hospital and reporting to the Minister.

(2) The committee, or any member or members, to whom a question is referred have all the powers, privileges and immunities of a commissioner appointed under the *Public Inquiries Act*.

Grants

66 If a Board fails to comply with this Act or the regulations, the Minister may suspend or adjust any grants or payments to which the hospital may be entitled under this Act until the Board complies with this Act or the regulations.

Agreements

67 The Minister may enter into agreements binding on a Board respecting the operation or administration of the mental health hospital or any diagnostic facility attached to the mental health hospital.

Regulations

68 The Lieutenant Governor in Council may make regulations

(a) governing the approval of the locations, design and construction of mental health hospitals and the conditions under which that approval will be granted;

(b) prescribing the standards of service to be provided by mental health hospitals;

(c) prescribing the admission policies of mental health hos-

pitals and types of patients that may be admitted to those hospitals;

(d) governing the disposal of human tissue, whether removed during an operation, autopsy or otherwise;

(e) prescribing the powers and duties of a Board with respect to appointment, reappointment, suspension and termination of appointment and the delineation of privileges of members of its medical staff;

(f) prescribing procedures for the mediation of a decision of a Board to refuse the appointment of a physician to its medical staff;

(g) governing the use of out-patient services and hostel beds instead of in-patient beds;

(h) prohibiting, except with the consent of the Minister, the sale, lease or other disposition of any facilities or equipment by a Board;

(i) prescribing the basis on which amounts of grants payable to a Board for operating costs and capital costs are determined;

(j) prescribing the rates and manner of payment by the Minister of his share of the operating and capital costs of a Board and the manner of accounting by the Board for those payments.

Agency

69 A Board is not an agent of the Crown in right of Alberta.

Transitional provisions

8(1) The Lieutenant Governor in Council may provide for the transfer of buildings and personal property used in the operation of the Alberta Hospital, Ponoka and the Alberta Hospital, Edmonton, as determined by the Lieutenant Governor in Council to the appropriate Mental Health Hospital Board, subject to any terms and conditions prescribed in the order and may declare that any debt or liability incurred by the Crown in connection with those hospitals shall become a debt or liability of the appropriate Board.

(2) The Lieutenant Governor in Council may make any order he considers necessary to provide for any matter not expressly provided for in this section for the purpose of

(a) facilitating any transfer and, without limitation, any other transitional matter, or

(b) remedying any hardship or difficulty arising from the establishment of a Mental Health Hospital Board.

(3) If a Board employs a person who at the time that this section comes into force is an employee of the Government employed at the Alberta Hospital, Ponoka or the Alberta Hospital, Edmonton, em-

ployment service of the employee with the Government shall be recognized by the Board as employment service with the Board.

RSA 1980 cF-9

9 The Financial Administration Act is amended in section 2(5) by adding the following after clause (e):

(e.1) a mental health hospital board under the *Mental Health Act;*

RSA 1980 cH-4

10 The Health Facilities Review Committee Act is amended in section 1(b) by adding the following after subclause (ii):

(ii.1) a mental health hospital under the *Mental Health Act,*

RSA 1980 cL-28

11 The Local Authorities Pension Act is amended in section 1(b) by adding the following after subclause (iii):

(iii.1) a mental health hospital board established under the *Mental Health Act,*

RSA 1980 cM-13

12(1) The Alberta Municipal Financing Corporation Act is amended by this section.

(2) Section 1 is amended

(a) in clause (h) by adding ", mental health hospital" *after* "hospital district";

(b) by adding the following after clause (h):

(h.1) "mental health hospital" means a mental health hospital under Part 5 of the *Mental Health Act;*

(3) Section 4(1)(b) is amended by adding ", mental health hospitals" *after* "approved hospitals".

(4) Section 5(2) is amended by adding "a mental health hospital," *after* "approved hospital,"

(5) Section 8(1) is amended by adding ", mental health hospitals" *after* "hospital districts".

RSA 1980 cO-7

13 The Ombudsman Act is amended

(a) in section 1(a) by adding the following after subclause (iv)

(iv.1) a mental health hospital board established under the *Mental Health Act,*

(b) in section 13(2)(b)

(i) by repealing subclauses (i) and (ii) and substituting "a place established under section 3(1) of the *Mental Health Act*".

(ii) by striking out "or institution".

14 This Act comes into force on Proclamation.

POOR

QUALITY

ORIGINAL